Psychiatric abuse and the concept of mental illness.

Al-Mutawa, Marwan S

A THESIS ENTITLED

PSYCHIATRIC ABUSE AND THE CONCEPT OF MENTAL ILLNESS

Submitted to
The University of Wales
in candidature for the degree of
Philosophiae Doctor

by

MARWAN S. AL-MUTAWA

April 1989

ABSTRACT

This thesis presents a critical analysis of the limitation and weakness of the concept of mental illness and proposes the Reactive Functional Disorder (RFD) approach as an alternative moral perspective on mental illness.

Chapter one highlights, through an analysis of the problems of psychiatric treatment in Kuwait, the vulnerability of the concept of mental illness to abuse. In Chapter two, it is argued that the current definitional systems used in psychiatry have contributed to the vulnerability of the concept of mental illness to abuse by employing definitions which are terminologically, clinically, and morally weak.

In Chapter three, the RFD approach is presented in the hope that this account might provide a deeper understanding of the moral and conceptual implications of the concept of mental illness.

Chapter four provides an analysis of some of the writings of Thomas Szasz, the controversial American psychiatrist, who argues consistently that mental illness is a myth and psychiatry is unlike other well-established medical disciplines. It is argued that Dr. Szasz, in reality, is less against psychiatry than against psychiatric coercion and involuntary hospitalisation.

In Chapter five, the current limitations of the concept of mental illness are discussed with special reference to political abuse of psychiatry in the Soviet Union. The RFD approach is applied theoretically to cases in the Soviet context in order to see whether this model might provide some way towards alleviating the problem of psychiatric abuse in the Soviet Union.

The final chapter argues that it is very difficult to establish a value-free model of mental illness due to the uniqueness and complexity of human personal suffering. It is concluded that what should be generalized is a definition of personal suffering that is based on a mutual patient-psychiatrist agreement on the content and frame of psychiatric interpretation.

The fundamental argument in this thesis is directed towards placing the patient's values and his personal definition of his suffering above the values of society or 'significant' others.

DECLARATION

All the work submitted in this thesis is the result of the candidate's own investigation except where I have indicated my indebtedness to other sources.

Candidate: .....

Date: .....6.:.4.:.1989.....

Supervisor: .....

Date: .....6 June 1989.....

I hereby declare that this work has not already been accepted in substance for any degree nor is it being concurrently submitted in candidature for any degree.

Candidate: .....

Date: .....6.:.4.:.1989.....

CONTENTS

ACKNOWLEDGEMENTS

I warmly thank my supervisor, Dr. Martyn Evans, for his encouragement and guidance. Without his support this work would not have reached completion.

I also owe a considerable debt of gratitude to Dr. Donald Evans, the Director of the Centre for the Study of Philosophy and Health Care for his consistent enthusiasm and for providing support at all stages.

I extend my gratitude to Dr. Geoffrey Hunt who kindly showed his interest and concern in my work.

I would also like to thank Mr. Daniel Rashid and all the staff in the Center.

Finally, I would like to extend my thanks to Mrs. M.E.Coles, who efficiently typed this work.

INTRODUCTION

The concept of mental illness is the focus of a deeply controversial debate concerning the validity and reliability of studying or specifying mental phenomena and the clinical reality of psychiatric labels. Philosophers, psychiatrists, clinical psychologists, social workers, sociologists, and other related professions such as lawyers, etc., have reacted differently to the concept of mental illness and psychiatry in general. Some argue for a radical departure from the current definitions of mental illness. Others raise doubts as to the applicability and usefulness of the study of mental phenomena and doubts as to psychiatry as a medical discipline. Such writers usually end with the conclusion that mental illness is no more than a myth or that mental illness is the expected result of being labelled as mentally ill. Such concern is centred on the moral and ethical outcome of psychiatric diagnosis and the need to promote and understand the mental patient's right to autonomy and self-government. Others, however (mainly traditional and organic psychiatrists), would take the opposite view that diagnosis and treatment in psychiatry have proved to be highly effective and reliable in many countries in the world. They claim that recent advances in genetic and neurological research will lead to a demonstration, in due course, that human suffering is predetermined by genetic factors. Such writers argue that the effectiveness of psychiatric treatment in severe psychotic conditions is a clear evidence of the chemical or organic basis of mental phenomena.

This thesis is an attempt at a moral and conceptual analysis of the moral limitations of the concept of mental illness. Moreover, the present writer hopes that such analysis is relevant to the problem of psychiatric abuse by showing how, in practice, the concept of mental illness is vulnerable to abuse. The vulnerability to abuse of the concept of mental illness will be analysed in Chapter One, "The problem of psychiatric treatments in Kuwait". This chapter will show that the concept of mental illness has contributed significantly to the problem of psychiatric abuse in Kuwait. Different forms of abuse are discussed with the support of case illustrations such as: involuntary hospitalisation, the use of ECT and other forms of medication, informed consent, and justice in the allocation of psychiatric resources.

Chapter two attempts to highlight the conceptual, clinical, and moral weakness of the concept of mental illness. It is argued that although many definition systems in psychiatry (such as DSM-III and ICD-9, etc.) provide us with a single definition of mental illness, clinicians in different countries are affected by their cultural norms of adjustment in the diagnosis of mental illness. Thus, a subjective rather than a clinical or observational set of symptoms is the central determining criterion in the diagnosis of mental illness. It is further argued that the morally negative outcome of psychiatric labelling is so significant and long-lasting that it will lead to an invalidation and dehumanization of those who are so labelled. Case illustrations and a review of clinical research will be discussed in order to show how the concept of mental illness can be vulnerable to abuse in psychiatric practice.

Chapter three argues that the RFD model (Reactive Functional Disorder) represents an approach which is morally advanced over the DSM-III. It will also be argued that such a model places the patient's values and his personal claims over socially accepted values. According to the RFD, the most important criterion for considering a person as suitable for psychiatric care should be the presence of clear indications of total functional failure in all his major psycho-physio-social functions as perceived by the patient himself. Furthermore, such a total failure is perceived to be the result of a reactive or external rather than an internal causal process. Throughout this chapter, case illustrations will be discussed in order to show the applicability of the RFD model in resolving problems of psychiatric abuse.

In Chapter four, we shall discuss the contribution of the American psychiatrist, Thomas Szasz, who argues consistently that mental illness is a myth and psychiatry cannot be defined as a medical discipline. For Szasz, mental illness is no more than 'problems of living'. Although Szasz expresses an extreme view of the concept of mental illness and psychiatry as completely governed by moral values, nevertheless his philosophical analysis has raised an awareness of the need to respect mental patients and the need for a psychiatrist-patient relationship based on consenting principles. It is further argued that in reality Szasz is not against psychiatry but psychiatric coercion and involuntary hospitalisation.

In Chapter five, we shall try to analyse the problem of political psychiatric abuse in the Soviet Union and to show how the RFD model can be applied to highlight political abuse in that country.

In the final chapter, it is argued that it is difficult, if not altogether impossible, to establish a value-free model of mental illness. It is further argued that current attempts to establish a value-free model of mental dysfunctions would not necessarily do away with the pejorative connotations of being mentally ill which are inherent in the concept itself. It is further argued that the 'biological' or 'disease' model cannot provide a satisfactory answer to many subjective elements in the interpretation of psychological phenomena, such as whether the patient's psycho-social functioning is reasonable or unreasonable or appropriate or inappropriate, etc. Throughout this chapter the importance of the shared interpretative agreement between the patient and the psychiatrist is emphasized. Both patient and psychiatrist should come to a mutual acceptance of the definition of the problem of functional failure. Thus, the agreement reached is likely to reflect more appropriately the shared perspective of patient and psychiatrist. Then it would seem possible to argue for an 'all-context' application of the above interpretative agreement.

CHAPTER ONE

THE PROBLEM OF PSYCHIATRIC TREATMENTS IN KUWAIT

THE PROBLEM OF PSYCHIATRIC TREATMENTS IN KUWAIT

Introduction

> "As people seek answers to current problems, they turn increasingly to the professional knowledge and insight of psychiatry. In turn, psychiatry interacts ever more with the political process, for without legislation, financing, and the concern of political leaders to nurture its services, psychiatry can achieve little."
> (Brown, 1975, p.2474)

In order to understand the interaction between psychiatry and society, and the problems posed by psychiatry in general, we need to analyse the hidden forces that determine the efficiency of mental health services and how psychiatry should deal with such forces.

This chapter will focus on the nature and character of problems specific to psychiatric treatment encountered during the writer's professional experience in Kuwait and will analyse historical development as well as contemporary practice.

When considering contemporary features of psychiatric problems in Kuwait, it is also necessary, however, not only to consider past and present conditions, but also to provide an account of psychiatric practice from ethical as well as psychiatric perspectives. A further aim of this chapter will be to evaluate from a moral standpoint the impact that psychiatric practice appears to have on mental patients in Kuwait.

The Concept of Health Care and Psychiatric Services in Kuwait

Kuwait's transition from a pearl-diving Bedouin society to a modern urban one has taken about forty years. Today, very few people depend on livestock or the sea for their living, most Kuwaitis are engaged in commerce or the service industries. At present Kuwait is one of the wealthiest countries in the world due to its rich oil resources. Another feature of the country is its rapid population growth. In 1957, only 200,000 people lived in Kuwait, whereas today there are 1.7 million, of whom just under half are Kuwaitis.

The State provides a comprehensive medical system, with access to a full range of free medical and psychiatric services. The country is divided into health districts containing about 25,000 people. Each district has a primary care clinic which provides general practitioner services. In Kuwait, there are six general hospitals with a total of 2,780 beds. In addition, there are specialist maternity, dental, orthopaedic, cancer, infectious diseases hospitals, and a psychiatric hospital (with psychiatric units in general hospitals and some primary care clinics). The line of referral to the Psychiatric Hospital is from the primary care clinics.

A. Philosophy of Health Care in Kuwait

In Kuwait, the legitimacy of the health care delivery system stems from the constitution which contains four articles providing the foundations of the State's philosophy of health care. These articles are as follows:

Article 1 The family is the cornerstone of the community. Religion (Islam), morality and patriotism for the homeland form the foundation for the family. Its existence is preserved by law which strengthens its ties and consequently protects the mother and child.

Article 2 The State provides care for the young and protects them from exploitation and from moral, physical and spiritual neglect.

Article 3 The State ensures aid to citizens in old age, or citizens who suffer from illness or inability to work, and provides them with social security and health care services.

Article 4 The State is responsible for public health and the means of prevention and treatment of diseases and epidemics.

A review of these four articles reveals that the philosophy governing the health care system in Kuwait is not restricted to the "conventional" preventive and curative services only. It goes far beyond those by making the State responsible for the social, moral and ethical development of its population. The salient elements of such philosophy are:

1. The type and level of health care to be provided to the population is to be compatible with the socio-cultural and religious values of Kuwaiti society. The needs of each individual are to be met in such a way that he or she can lead a socially, economically, and emotionally productive life. In fact, one could make a useful comparison with the WHO definition of health. The World Health Organisation (WHO) in 1946 (Callahan, 1976) defined Health

as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p.160). Clearly, the WHO definition emphasized the importance of the interconnection between physical and social and psychological well-being (see Harron et al, 1983). Moreover, the WHO definition of health "encompasses everything that could be included under the heading of human welfare and happiness" (Callahan, 1976, p.160). It is indeed a very broad definition that conceptualises many aspects of human problems can be solved within medicine. Many developing countries, including Kuwait, adhere almost exclusively to the WHO definition of health. However, as Callahan (1976) argues, such a definition is, by the virtue of its broadness, open to abuse. The WHO definition, in addition, has led many clinicians throughout the world to conceptualise moral and ethical spheres of activities such as political or criminal behaviour as an indication of 'sickness', rather than "just wrong, stupid, or immoral" (Callahan, Ibid., p.160) which indicate to the WHO's definitional power of Health.

> "Moreover, it is patently the case that the combination of an all-encompassing concept of health together with biomedical advances has created a situation in which nearly anything that anyone wants from medicine can find legitimation as a health need. The abortion reform movement, culminating in the Supreme Court decision to allow abortion on request for the first two trimesters of pregnancy, drew heavily on health and well-being arguments, and the wording of the court's decision made much of putting the final choice jointly in the hands of women and their physicians, as if it were simply a medical matter. The emergence of genetic counselling as a major medical profession has drawn much of its force not only by concentrating on the genetic health of fetuses and neonates but also and

> simultaneously by concentrating on the mental health of parents faced with the possibility of producing a defective child. The word "suffering" is a common one in the literature of genetic counseling, but it is rarely clear whether the suffering referred to is that of the child, the parents and family, or the society as a whole; they are usually mixed together in ways that make them almost indistinguishable. "Health", now seen as the alleviation of all suffering, provides a very handy basket into which can be thrown both physiological considerations and emotional responses." (Ibid., p.160)

Thus, "any desire can be seen as a health need; and any need can be legitimated in the name of the right to health" (Ibid., p.161). In our following discussion of the problematic nature of psychiatric services in Kuwait, we shall see how in the name of the right to mental health, many patients have been deprived from their basic rights and humanity and some psychiatrists have abused their professional power.

2. The special health needs of specific sub-populations such as the under-privileged, the handicapped, children, mothers, and the elderly are to be given a higher priority.
3. Community participation is viewed as an essential element of health and of health care.
4. The Ministry of Public Health will devise, test and implement standards in all spheres of health activities.
5. Health manpower is to be trained to meet the highest professional standards, while the dependency on ex-patriate health manpower is progressively reduced.

B. The Psychiatric Hospital and Psychiatric Patients: A Moral and Historical Perspective

Before 1940, psychiatric patients in Kuwait were neglected, left wandering in the streets and the market centres. In 1940, the Kuwaiti Municipality recommended an institution for the "insane" be established. The patients were "collected" and put under the full care of "guards" who fed them, chained and unchained them, and generally supervised their lives.

In 1949, a small hospital for psychiatric cases was built. The hospital was originally known as the "Lunatic Asylum" and here the mentally ill were handled in the manner associated with the word "lunatic". That is to say, they were locked up, not with any idea of treatment, but to prevent them from harming other people. The hospital's rooms were narrow, barred cells where the patients could be chained, and in each courtyard stood a large cage where they could be incarcerated in the day-time.

By 1955 the old ways had been partially abandoned. Since then conditions have steadily improved in the following areas:

- provision of decent accommodation;
- introduction of medical treatment (e.g. insulin therapy, medication, etc.);
- employing doctors and nurses;
- improvement of the administrative regulations of admittance and discharge of patients.

A general view of the first psychiatric hospital in Kuwait which was built in 1949 and was originally known as the "Lunatic Asylum".

(Source: Al-Mutawa, 1986, p.54).

In the 1970s, there was no clear definition of what mental disorder was, and certainly no recognition of the mentally ill as a category requiring a special form of treatment. Only a small proportion of the total number of disturbed people were recognised as being "insane". A person who was labelled as "insane" was a person whose actions were obviously a danger to himself or to others, and

such an individual had no protection at all in law. He might be sent to the "Lunatic Asylum", the only place which dealt with such problems.

Many Kuwaiti families, however, preferred to keep their mentally disturbed members at home and lock the door on them. "Patients" were almost certain to be confined most of the day, neglected and intimidated.

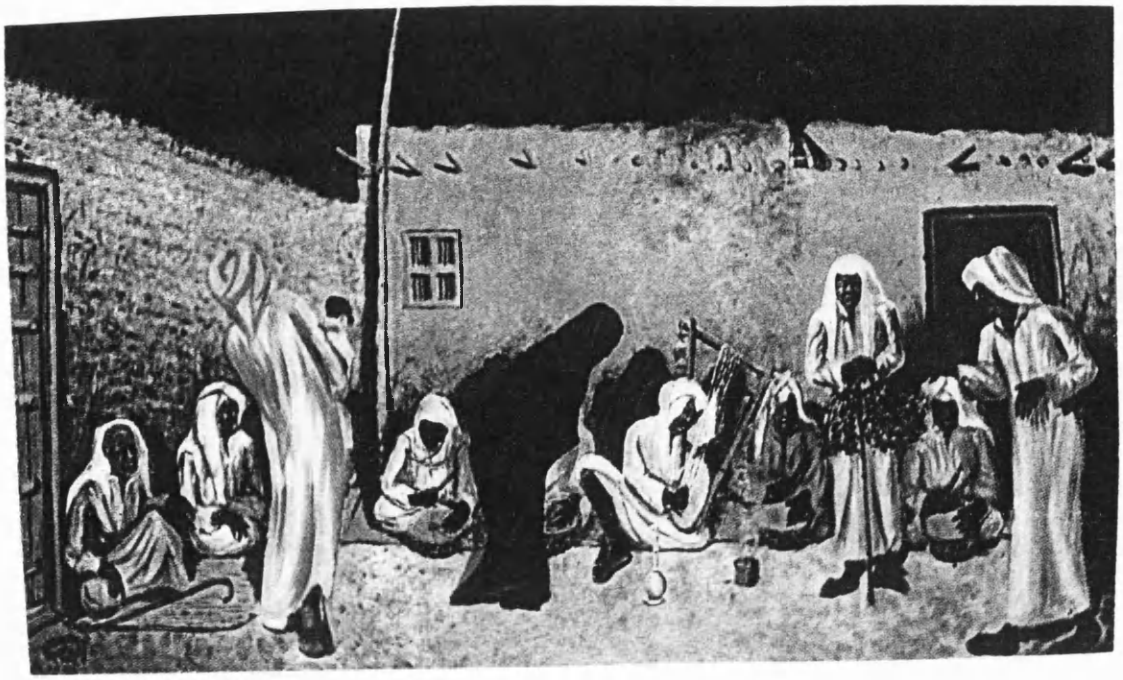
Many families refused to send their patients to the hospital because of the following reasons:

(1) the stigma and shame which society attached to such disorders;

(2) sending a family member to the "Lunatic Asylum" would be seen as a sign of failure to cope with the problem;

(3) sending the patient to the "asylum" might be taken to mean that the family wanted to get rid of their relative because they did not care enough about him/her;

(4) many Kuwaiti families viewed mental patients as victims of evil forces, evil spirits, or as possessed by demons.



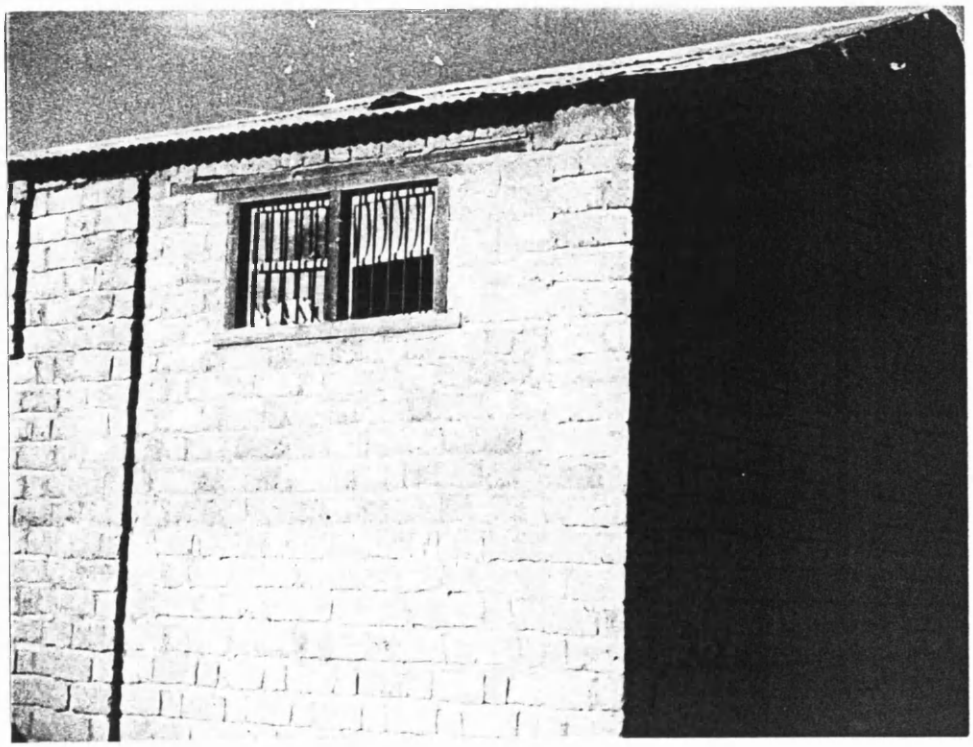
"Al Tanbora" - a traditional Kuwaiti dance, which many families believed was effective in curing mental illness by exorcising the patient from the evil spirits.

A Talisman (charm) which was thought to be an effective protection from the "evil eye" or spirits.

(Source: Hussain, 1984, p.140).

The general resistance on the part of the family to send their patients to the psychiatric hospital moved some psychiatrists in 1957 to make special arrangements with some families to accept patients whose family had failed to cure by using traditional methods. The politics of this practice are very clear. The hospital wanted to encourage people to use its services and to support its legitimacy as a medical psychiatric institution, and not a "lunatic asylum".

This policy, unfortunately, made the psychiatrists and physicians who worked in the "Lunatic Asylum" over-emphasise their professional links with colleagues in general physical medicine. The result was that the hospital policy seemed to rely quite heavily on physical methods of treatment, such as anti-depressant, anti-psychotic drugs and, latterly, ECT. Psychotherapy was and still is considered to be an ineffective method of treatment and a waste of time.



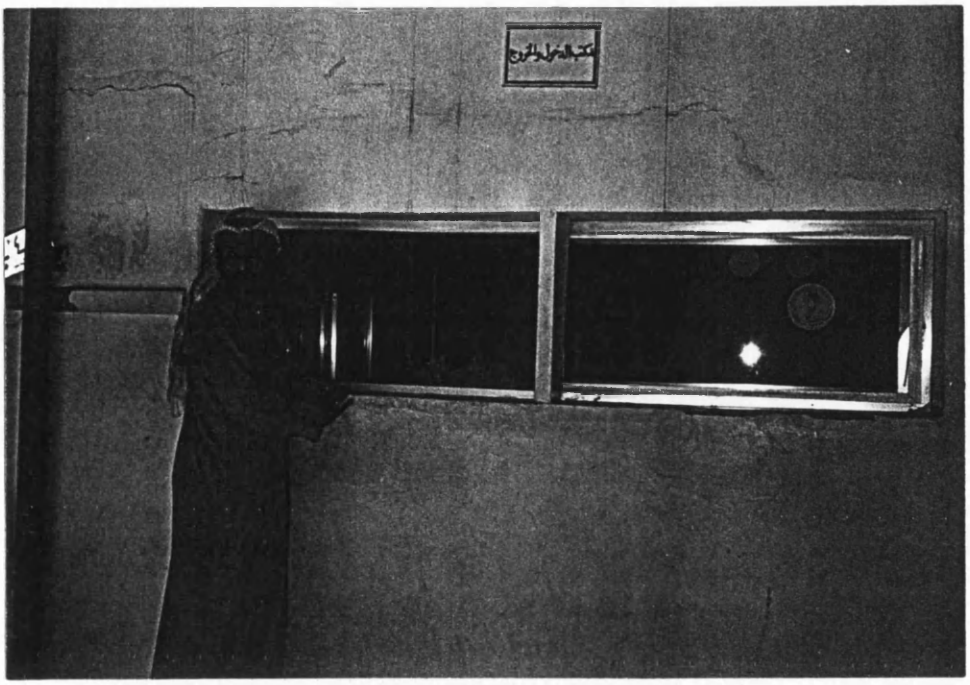
A hospital ward in the old "Lunatic Asylum" which was built in 1949. (Source: Al-Mutawa, 1986, p.20).

A completely new Psychiatric Hospital was eventually built in 1958. Initially it had beds for 136 patients, and dealt mainly with patients suffering the early stages of mental disorder, alcoholics and psychological cases. The old "asylum" was still reserved for the seriously mentally ill. However, this was closed in 1963.

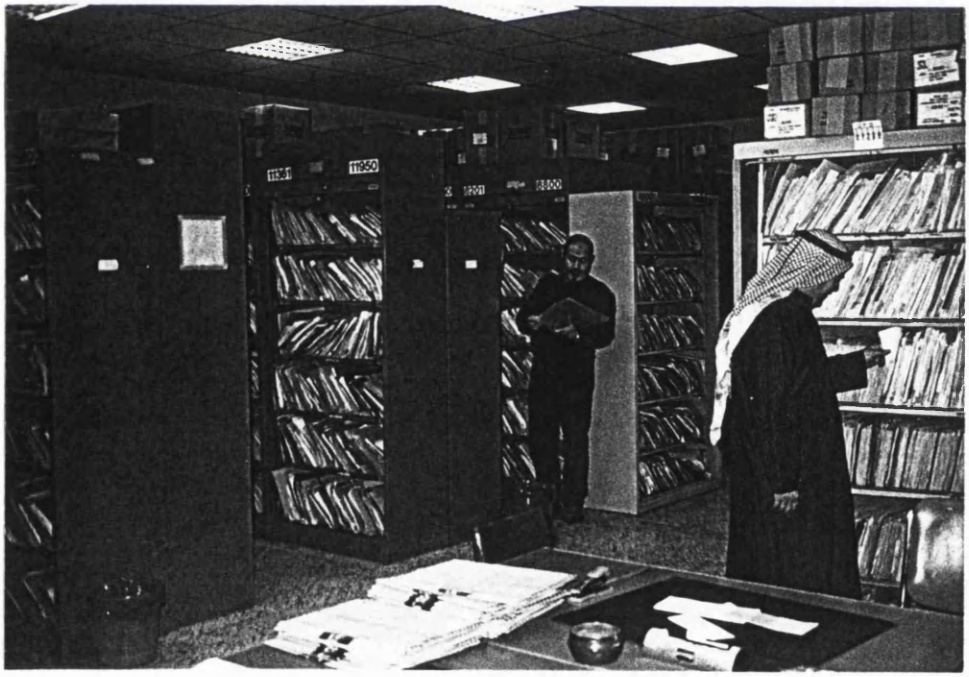
Today, the only Psychiatric Hospital in Kuwait is the one which was built in 1958. Since 1958, the hospital capacity has grown steadily, and the buildings are under constant construction and extension. At present, the hospital accommodates 500 patients within nineteen wards.

Development in psychiatric services in Kuwait of recent years indicates that mental health professionals have travelled far beyond the walls of the old "asylum" (their original place of work). Today their functions have been extended to the military services, schools, child and family guidance clinics, prisons, and several psychiatric out-patient clinics in general hospitals.

The new "Psychiatric Hospital" in Kuwait which was built in 1958. This is the only psychiatric hospital in Kuwait. (Source: Al-Mutawa, 1987, p.3).



The admission and discharge office in Kuwait Psychiatric Hospital



Patients' medical records to which every person working in the hospital has access

(Source: Al-Mutawa, 1986, p.25).

ECT (electro-convulsive therapy) equipment which is currently in use in the Psychiatric Hospital.

(Source: Al-Mutawa, 1986, p.32).

The Problem of Psychiatric Treatment in Kuwait

1. Involuntary Hospitalisation and the Principle of Liberty

M.M. is a highly intelligent 37-year old married man with a secondary level of education who used to be employed in his father's trade company. When he was 22, he suddenly began to feel highly suspicious of his older brother because he thought that his brother (who was the managing director of the family trade company) was mishandling the company money. The case told his father that he wanted to be on the board of the company. However, his application was refused. The case then became very angry, agitated, suspicious and aggressive toward employees in the company. His older brother was annoyed by the case's continuous interference in his work, so he called the police who arrested the case while he was on his way to his house. The case was diagnosed as paranoid psychotic. On examination, the patient appeared confused and disoriented. Although he is an Arabic speaker, he preferred to speak in English (which was taken by the psychiatrists as an indication of thorough mental disturbance). He was then admitted to a closed ward and was treated with anti-psychotic medication and ECT, which produced the following side-effects: dry mouth, constipation, drowsiness and memory disturbance. After he was discharged, he stopped taking the medication.

After a while, he began to interfere again with his family company and asked his father to give him a new house (the father had already given all his sons new houses). The father refused to comply with his wish, upon which the case accused him of not being fair to all his sons.

Eventually, the patient suspected that his older brother would arrange for him to be re-admitted to the hospital, so he escaped to his older sister, who was very fond of him, and stayed there for two weeks. When he felt that he was probably safe, he went back to his own house. At 10.00 p.m. one night soon after, while he was sitting with his wife and three of his children, two ununiformed males knocked on the door. His wife opened the door and they asked to speak with the case, claiming that they were old friends. When the case came to the door, they jumped on him, held him down, and gave him an intravenous sedative injection. Then they took him to the hospital. Some two months after the re-admission, the patient began to suspect that he had been deprived of his freedom, not so much because he was really sick, but because he had annoyed his older brother.

The Ethical Dilemmas of Involuntary Hospitalisation in Kuwait

In any attempt to analyse the moral and psychiatric dimension of involuntary hospitalisation, one needs to affirm several assumptions which are central in any discussion of this subject. First of all, the individual's autonomy and liberty should be given a high priority in psychiatric practice. Secondly, certain values such as justice, equality, autonomy, improving the quality of life, and other humanistic principles, should also be promoted in psychiatric practice (see Torrey, 1985). Thirdly, the patient's right for self-definition must also be respected.

However, the above principles often come into conflict in actual practice, as we will see in the following pages. That is to say, the 'patient's' right to have a free or autonomous choice could be put in jeopardy if he is perceived by the psychiatrists as lacking the basic attributes for rational calculation or sufficient understanding, or reasonable estimation of the consequences of his condition or the medication being offered (Ibid., 1985).

The patient in the case illustrated above highlights some of the above dilemmas of involuntary hospitalisation. The problem of compulsory admission has been the subject of a continuous debate between psychiatrists, philosophers, sociologists, and many other groups (such as ex-patriate groups). A careful examination of this debate would reveal that there are two kinds of attitudes towards the problem. First, there are the opponents of compulsory hospitalisation, represented by psychiatrists such as Thomas Szasz, R.D.Laing, Russell Barton, sociologists such as Goffman, Thomas Scheff, and philosophers such as John Stuart Mill. Mill argues throughout his many books that there is a moral obligation on societies to respect the individual's autonomous choice and to eliminate any form of coercion against the individual. For Mill:

> "The proper object of sanitary laws is not to compel people to take care of their own health, but to prevent them from endangering the health of others. To prescribe by law what they should do for their own health alone, would by most people be regarded as something very like tyranny." (Mill in Rayan, 1987, p.251)

Clearly, Mill's position is that any society is free from this moral obligation towards the individual if the individual's acts become evidently dangerous to the well-being of others. Mill's views on the individual's freedom, ethics, utility and liberty have inspired many mental health professionals and philosophers to promote the individual's right for freedom and autonomous choice (see Mill 1910, reprinted in 1983). However, what are the grounds which permit us to accept the general notion that being a danger to oneself or others is a sufficient condition for depriving the patient of his basic human rights, i.e. freedom of choice and self-definition of his suffering?

Some researchers have correctly shown that the concept of dangerousness to oneself or others is imprecise, loose, and a relative one (see Levinson and Ramsay, 1979; Callahan, 1984; Humber, 1981; Cocozza and Steadman, 1985; see also Steadman, 1983; Harding and Adserballe, 1983). The problem with the concept of dangerousness "... is not that the patient will be dangerous or that he falls within a class of patients some members of which frequently exhibit dangerousness. A more valid criticism of psychiatrists in my mind is that they have not been diligent enough in following the patient and stating when the possibility of dangerousness has passed and when it is time for the patient to be released" (Robitscher, 1977, p.381).

Another justification for abolishing involuntary hospitalisation for those writers who argue against such procedures is the problem of long-lasting stigma and the diminishment of civil rights

and moral status which are associated with the mental patient's career in the hospital (see Torrey, 1986).

Robitscher (1977a) has summarized in his article "Psychiatric Labelling, Predicting, and Stigmatizing", the various reasons according to which the psychiatrists can interfere with the individual's right to have an autonomous choice. They, the psychiatrists, can:

1. determine the financial competency;
2. control the marriage and divorce of the labelled individuals;
3. deprive the labelled individuals from their children;
4. "negate the intention of a dead testator by stating that he lacked testamentary capacity" (p.350);
5. recommend sterilization for mentally ill women;
6. decide who goes to prison and who goes to hospital and who is incompetent to stand trial;
7. determine the competency of individuals with terminal disease to end their life (see also, Lemert, 1951; Schrag, 1980).

Robitscher cited 22 examples of how psychiatrists can impose their 'clinical expertise' on every aspect of the individual's life. However, it would be beyond the scope of this chapter to discuss them in detail.

Another major argument against compulsory admission to mental hospital is the vulnerability of such procedure to abuse. If any given country has the right to hospitalise people against their true desires and best interests, then it will create subjective and arbitrary

criteria for such hospitalisation and therefore use it to oppress political dissenters as in the Soviet Union, for example, or troublesome individuals, etc. (see Robitscher, 1977a and 1977b).

Thus, the central argument against involuntary hospitalisation is best illustrated when considering the fact that the criteria on which people are admitted compulsorily are not always objective. What often happens is that the labelled individuals are committed for ten to thirty years for non-conformity rather than on the basis of objective symptoms as experienced by the individual himself.

The problem of many mental health professionals is that they disregard the fact that "some religious and political beliefs can convert almost any seemingly irrational act into a rational one" (Culver and Gert in Brown, 1985, p.559), which means that not all irrational behavioural frames must necessarily be based on unintelligible content. The problem is that psychiatry has traditionally viewed the 'insane's' content and frame of beliefs as "... unconscious distortions of reality, as food for the interpretive grind, and are not taken at face value" (Weinstein, 1981, p.303).

On the other hand, advocates of involuntary psychiatric hospitalisation present the view that the mentally ill are not fully aware of the side-effects of their 'underlying disease'. For those who argue for compulsory admission, being mentally ill will surely lead the person to lose his insight of how to care for himself or to act in his best interest. In such cases, the state has an obligation

to protect the individuals from themselves and to protect others. That is to say, that the concept of dangerousness to oneself or another is a crucial determining criterion for psychiatric involuntary hospitalisation.

However, as was pointed out earlier, the concept of dangerousness is not always accurate and one of the central problems facing psychiatrists in their daily practice is how to draw a line or to differentiate between a persistent form of dangerousness and an occasional one? Or how to make a precise decision on how much the patient is dangerous to himself or others? Thus it seems very difficult to attain an effective balance "between the patient's right of self-expression and society's obligation to protect other citizens from the consequences of that self-expression" (Torrey, 1985, p.186).

In conclusion, it could be argued that the psychiatric 'medical' approach is influenced mainly by utilitarian or consequentialist ground, whereas the anti-psychiatry movement or those who argue against the medical model in psychiatry adhere to the deontological or absolutist position by maintaining that certain principles (e.g. liberty, justice, autonomy, etc.) should be the central element in our judgment and the only criteria of appropriate psychiatric judgment. On the whole, the question of involuntary hospitalisation is a moral concern and, as such, very difficult to resolve convincingly. The right of the 'patient' to have control over his total life might conflict with the state's responsibility for preventing or treating any forms of illness that might cause distress to the patient himself or others (see Hare, 1981).

Now let us consider the current problem of involuntary hospitalisation in Kuwait. We can begin by stating that the psychiatric service in Kuwait is in a state of moral and ethical crisis which is continuously deteriorating. To begin with, patients are admitted straight from the emergency room with minimal, if any, psychiatric history or proper assessment. Now, it is a well-known fact that the emergency room is one of the most vital areas in any psychiatric hospital. Emergency work should be characterised by prompt decision making and sound clinical judgment. Therefore, there should be a holding area attached to the emergency room where patients are observed for a few hours before deciding on the appropriate action to be taken (Al-Ansari, 1985).

The absence of a holding area has resulted in admitting almost all cases that come to the emergency room after 1.00 p.m. (the end of morning shift). This often results in the admission of cases which do not really require psychiatric commitment (Ibid., 1985).

This kind of practice has changed the hospital from a therapeutic environment to a detention centre for people considered to be "mentally ill" by non-professionals such as the public, the police, the family, etc., and even for people with personality disorders for whom psychiatrists have no adequate treatment. Unfortunately, psychiatrists tend to regard long periods of hospitalisation as effective treatment in itself.

In Kuwait, almost all mental patients including schizophrenics are involuntarily admitted, as a matter of practice. For many psychiatrists, compulsory hospitalisation is more important than the patient's right to liberty and autonomy. According to the 1982 study conducted by the Faculty of Medicine in Kuwait (Mekkawi et al) on 165 chronic mental patients, mental patients were brought to the hospital compulsorily by the following agents (see Table 1).

TABLE 1: Source of Admission in Relation to Sex

Source of Admission / Sex	Police	Relatives	Both	Unknown
Male	23 (25.3%)	53 (58.2%)	6 (6.6%)	9 (9.8%)
Female	7 (7.4%)	48 (64.8%)	2 (2.7%)	17 (22.9%)
Total	30* (18.2%)	101 (61.2%)	8 (4.8%)	26 (15.7%)

*(In 1986, the number of cases brought in by the police was 997.)
(Source: Mekkawi, 1982, p.5)

The study also shows that schizophrenia was the most common mental disorder among the patients. The next most common disturbance was combined mental disorder in which the patient suffers from more than one mental abnormality. However, one of the most crucial results of this study is that 50% of the university staff were shown to believe that the mental patients admitted had not been correctly diagnosed.

In fact, many mental patients are admitted to the Psychiatric Hospital in Kuwait for a variety of non-clinical reasons (see Mendele Rapport, 1969). It may be that the psychiatrists feel that the patients

do not have any place to go (many Kuwaiti families think that the hospital is a refuge for mad persons), some patients are referred from the general hospital because they have been disturbing others, another group of patients have social problems which make it impossible for them to stay at home so the only refuge for them is the hospital. Still another group of patients is readmitted to the hospital after being discharged, on the basis of a telephone call from their families. The last group is the mentally retarded patients who are not accepted by the appropriate institution and so they are admitted to the Psychiatric Hospital instead (Makkawi, 1982). (For a detailed analysis of the role of non-clinical or subjective factors in psychiatric admission, see Townsend, 1980; Holmes and Solomon, 1981; Perrucci and Targ, 1982.)

In reality, the decision for involuntary confinement is usually taken late at night, and the individual is often accompanied by the police or a relative. This means that admission to the Psychiatric Hospital in Kuwait is largely governed by the attitudes and wishes of the patient's family or relatives rather than by the actual symptoms and complaints of the patient as perceived by himself (see Greenley, 1975). The relatives may be emotionally stressed and may reflect their worries and upset by insisting that the patient must be admitted to the hospital. The patient, in many instances, may react to the family or police attitudes in an angry or confused way or he might refuse to communicate which reinforces the view that he is really 'mentally ill'.

The psychiatrist in charge may lack the counselling facilities or sufficient time to seek a second opinion or consultation. Thus, "if there is pressure to admit a person to the hospital, the psychiatrist will look for behaviors that are symptomatic and permit the statement that a particular syndrome exists. Once this has been accomplished, he can make a medical decision, a diagnosis, and hospitalise the individual. The patient is shaped into giving the physician what is wanted and expected" (Ullman and Krasner, 1973, p.299).

If the psychiatrist in charge failed, for example, to respond to the family desire to commit one of its members, it would be interpreted as a sign of incompetency on the part of the psychiatrist and may place the psychiatrist under legal and administrative risk. In the Psychiatric Hospital in Kuwait, the vulnerability of the involuntary commitment procedures to abuse is due to the following factors:

(1) "The power and authority of junior staff in the hospital which is accorded as a reward for their increased responsibilities. In reality there are no junior physicians in the hospital. An assistant registrar assesses, admits, treats and discharges a patient on his own with minimal if any senior physician's supervision. This responsibility was granted to junior staff gradually and progressively over the years to become an established rule which is not questioned." (Al-Ansari, 1985, p.7).

(2) There are a few psychologists in the Psychiatric Hospital in Kuwait, most of whom lack clinical knowledge and training. They administer psychological tests that are unreliable and poorly standardised. Some psychologists conduct psychotherapy without any clinical training or supervision. Psychologists

are usually looked down upon and are isolated and undermined by different staff of the hospital. The same is applicable to the social workers who work there.

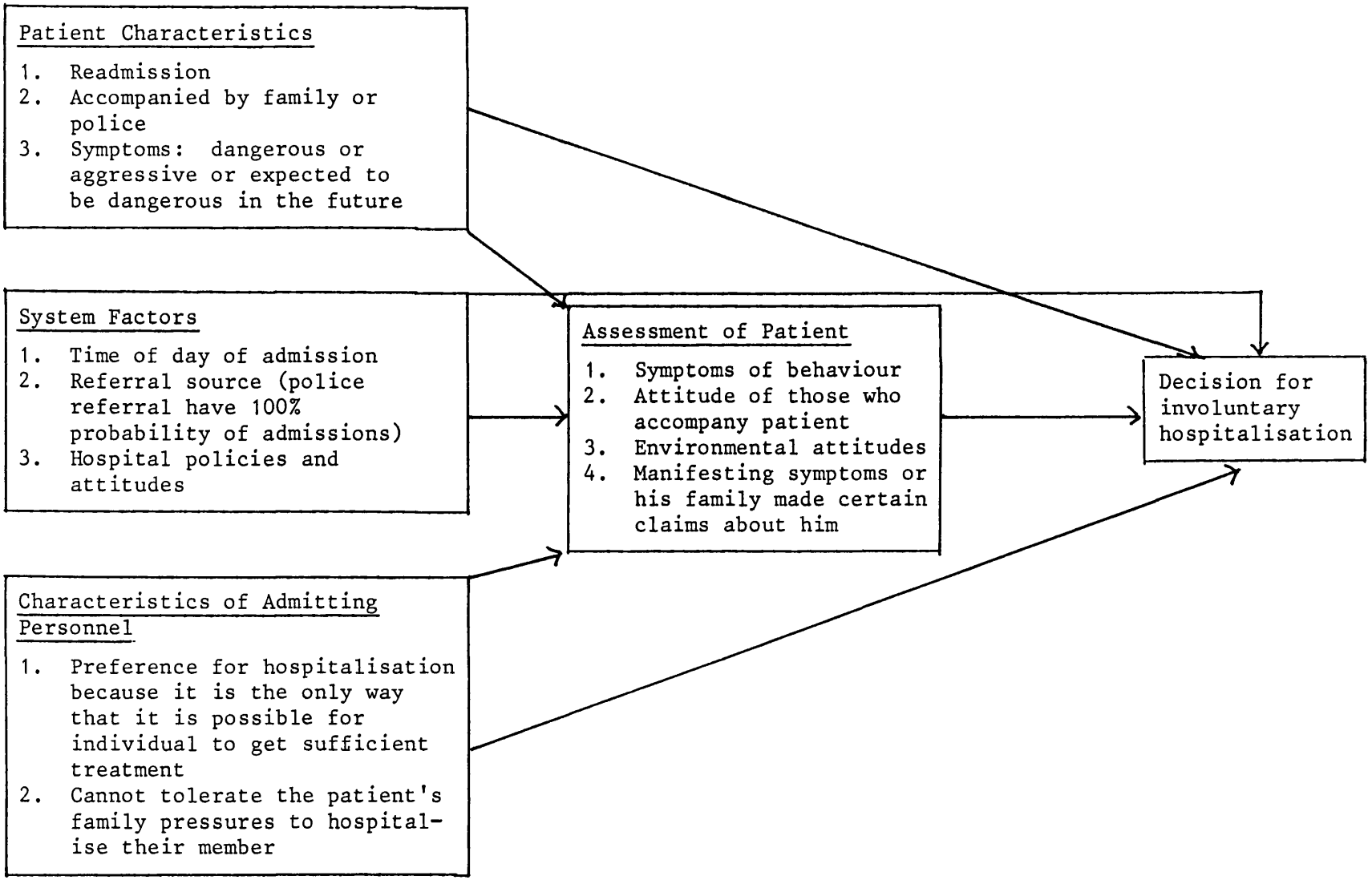
(3) There is a significant lack of adequate communication between the mental health professionals (psychiatrists, psychologists, social workers, and nurses), and the administrative staff. Such lack of communication has contributed in isolating those two sides which consequently has led to the inadequacy of the general psychiatric services presented to patients.

(4) The major criteria for involuntary psychiatric hospitalisation in Kuwait are:

- the patient might cause harm to himself or others;
- the patient's previous history of hospitalisation; (see Mendel and Rapport, 1969);
- the source of referral, i.e. if the 'patient' is accompanied by the police or family member, his 'illness' would achieve a greater validity and could bring pressure to the admission psychiatrist;
- the time of referral: the patient is likely to be admitted involuntarily if the application is made at night-shift. (For more details on the factors that influence psychiatric admissions, see Holmes and Solomon, 1981.)

The processes and factors affecting involuntary hospitalisation could be summarised in the following figure (see Figure 1) which was originally adapted with certain changes from Holmes and Solomon, 1981, p.204.

FIGURE 1: Conceptual Model of the Decision to Admit Involuntarily to The Psychiatric Hospital in Kuwait



Now, cases like that of M.M. which we mentioned earlier in this chapter, are common in the Psychiatric Hospital in Kuwait. They raise many moral and ethical questions which need to be resolved. One of these central questions is: do mental health professionals have the right to promote M.M's mental health at the expense of his right for self-determination?

In cases like M.M., concern for the individual's mental health might conflict with his right to have an autonomous decision (on the assumption that psychiatric hospitalisation can be of benefit to his mental health. Without this assumption there is no real dilemma - hospitalisation would be straightforwardly unjustifiable.) So, there is a basic conflict between two moral principles: the principle of beneficence, and the principle of respecting people's liberty to define their own interests.

In actual psychiatric practice, there will be many borderline cases where one cannot predict confidently whether the patient should be allowed to live outside the boundaries of mental hospital or be committed to the hospital against his will.

What mental health professionals need is to conduct a careful estimation of the moral and practical use of the principles of beneficence and liberty in relation to the mentally ill individual. In this context the psychiatrist has to accept a moral obligation to provide an autonomous therapeutic help to a patient who lacks (maybe temporarily) the capacity but not the basic

will and self-determination (Edwards, 1967, and Wear, 1982), to be capable of voluntarily accepting or rejecting the psychiatric help. (For more details on the concept of autonomy as it is related to the patient's self-definition in psychiatric practice, see Perry, 1985. See also, Chodoff, 1984, for the moral dilemma centred around involuntary hospitalisation.)

2. The Use of ECT and Medication in the Psychiatric Hospital in Kuwait

Case illustration:

Mr. A. is a 38-years old single male patient with a past history of violent sexual behaviour. Mr. A's problem was that he would not resist his sexual impulses when confronted with a woman in the street. Often he would follow women to their houses, attack their husbands (if married) and rape the wives. Eventually, Mr. A. was arrested and jailed for rape.

At the end of his prison sentence, he visited the Psychiatric Hospital to see a psychiatrist who diagnosed him as schizophrenic due to the presence of aggressive sexual behaviour, emotional ambivalence, and thought disturbance (concerning the motives for his sexual attacks on women). On the first occasion of psychiatric treatment in the Kuwait Hospital, the case received ECT and anti-psychotic medication. After his discharge his family noticed that the patient manifested certain side-effects of the treatment such as dry mouth, drowsiness, which caused him to have a car accident, restlessness and blurring of vision. During the patient's second visit to the hospital, his

family refused to consent to any form of psychiatric treatment due to the side-effects of the psychiatric medication.

Now, a philosophical question arises from these two cases, namely: Can a family reasonably refuse specific treatments for the patient? If so, could reasonable grounds include doubts about professionals practice, or doubts (held by the family who are laymen) about efficacy, or about balance of good over harm?

To bring the subject of the ethical and professional problems of psychiatric practice in Kuwait into focus, it may be helpful to consider some more facts illustrating psychiatric treatment in Kuwait.

Psychiatric Treatment Methods in Kuwait

A. Psychopharmacology

The practice of psychopharmacology in the Psychiatric Hospital in Kuwait lacks sound clinical judgement and is potentially hazardous.

> "Often drugs are combined without proper scientific research. Polypharmacy tends to be the rule rather than the exception in the management of most patients in the hospital, and many patients are treated and maintained on five to six different medications. Moreover, there is a strong temptation for the psychiatrists to resort to continuous "drugging", the so-called "maintenance therapy" and that is because medication does not remove the source of the disorder." (Al-Ansari, 1985, p.13)

What is remarkable is that such treatment is prescribed and practised by senior as well as junior staff. This practice indirectly contributes to non-compliance with treatment and increases the possibilities of adverse drug effects and re-admission.

B. Electroconvulsive Therapy (ECT)

In North America, ECT is used in 3-6% of all patients admitted to psychiatric hospitals. European studies have shown a slightly higher rate. In Kuwait, the frequency of ECT use is 33% - this means that one in every three patients admitted to the hospital receives ECT (Al-Ansari, 1985). It is obvious that the above figure is unusually high and suggests overuse of ECT. In January 1985, 54% of the total number of admissions and out-patients in both male and female (which was 264) received ECT.

In addition, patients are poorly prepared for ECT - 50% or more of them are not even physically examined. Most patients' charts reflect the following:

(1) the absence of psychiatric diagnosis or any criteria for reaching a diagnosis;
(2) absence of basic physical examination and routine laboratory testing;
(3) absence of a proper detailed psychaitric history, mental state examination (psychological tests, reports) and follow-up notes;
(4) lack of senior psychiatrists' notes and direct involvement in the patient's care and management.

Therefore, it appears that the indications for ECT use are ill-defined. In many cases the application of ECT is unjustified and not indicated. In view of the percentage of patients routinely undergoing what is elsewhere generally a controversial and less-used therapy, and in view of the lack of indications for its use, it would not be an exaggeration to state that ECT is definitely abused in the Psychiatric Hospital in Kuwait. Some of the factors responsible for this are:

1. poor training and supervision of junior staff;
2. indifference and apathy on the part of senior staff;
3. the increasing number of patients that have to be managed;
4. superficiality of assessment procedures with no regard at all to the physical, medical, and psychological factors that could be responsible for the patient's symptoms. A few incoherent statements are written down in the file and the patient is guided to the ward. In fact, some psychiatrists and psychologists have pride in their ability to reach a diagnosis within a few minutes without conducting any psychological or physical tests.

In summary, individuals diagnosed as psychotic in Kuwait are invariably:

(i) treated compulsorily;

(ii) hospitalised;

(iii) given anti-psychotic medication and ECT; and

(iv) certified as mentally and legally incompetent.

(Townsend, 1980)

Little, if any, consideration is given to the moral dimension of psychiatric responsibility, labelling, and practice.

The Availability of Alternatives: Psychological Treatment Methods in the Psychiatric Hospital in Kuwait

A. Psychotherapy, Behaviour and Occupational Therapy

Psychotherapy is indicated for many psychiatric disorders. It can modify and improve psychological symptoms when drugs are not indicated and can contribute to the proper psychological adjustment of many patients.

It is not our objective in this chapter to discuss the suitability of psychotherapy for psychiatric patients in Kuwait. Instead, the focus here is on the general picture of psychotherapeutic practice in the Psychiatric Hospital in Kuwait. Unfortunately, psychotherapy, whether it be behaviour therapy or occupational therapy, is rarely offered or performed as a treatment modality.

B. Rehabilitation

Psychiatric rehabilitation is crucial for the achievement of maximal functioning of the patient and better adjustment in society. Different studies have demonstrated that adequate psychiatric rehabilitation programmes have two major advantages (see Birchwood et al, 1988):

(i) to decrease the rate of relapse and re-admission to hospital;

(ii) to improve the psychological and occupational adjustment of psychiatric patients (see Rosie, 1987 and Dorwart, 1988).

Unfortunately, this essential procedure does not exist in the Psychiatric Hospital in Kuwait. In 1983, there were 4,270 admissions to the hospital. Of these, 1,130 (26.4%) were new cases, while 3,140 (73.5%) were re-admissions. Many of the re-admissions were the fourth or fifth in that year above. One of the most crucial factors responsible for this is the absence of a comprehensive rehabilitation programme and scientific psychotherapeutic treatment (Al-Mutawa, 1986, and 1987).

Schizophrenic or depressed patients are usually discharged prematurely, maintained on several drugs with next follow-up outpatient appointment lasting between 7-13 minutes after one or two months. How can we expect such procedures to help the patient to function adequately in society?

In summary, the treatment modalities offered in the Psychiatric Hospital in Kuwait lack a total approach for the individual patient and are severely deficient. The consequences are that the re-admission rate is very high and the "revolving door" phenomenon is very common.

The following pictures show the present writer's personal project in 1982 on applying a social skills rehabilitation programme on the chronic mental patient in the Psychiatric Hospital in Kuwait. (This programme was basically dependent on limited private funds. For that reason, the project did not attain a significant success due to its termination after a period of three months.)

Patients at lunch in a public restaurant.

Patients shopping.

Mental patients taking their lunch
in the countryside.

Dancing and eating on the beach.

3. Informed Consent and Psychiatric Practice in Kuwait: The Problem of Decision-Making in the Psychiatric Hospital

The central ethical principle of informed consent is based on what Szasz (1984b) calls a "consenting adults" base relationship between the psychiatrist and patient.

The ethical basis of informed consent can be established on either one of two ethical principles. It can be grounded in the "deontological" or absolute principle, by arguing that informed consent is intrinsically "good" because it represents the growth of the general obligation of one human being to another. Alternatively, it can be based on consequentialist or utilitarian principles by arguing that the morally significant issue of informed consent depends on the benefit or ultimate 'good' to clinicians, patients, and the public in general (Faulder, 1985; Lidz et al, 1984; Chodoff, 1984).

The basic premise of informed consent in psychiatry is that the patient is a self-determining person who is prima facie capable of making treatment decisions based on sufficient information provided by the clinicians involved. Moreover, the patient (especially the psychotic) may temporarily lack the capacity but not the will and motives to be a rational agent (see Wear, 1980 and Edwards, 1982 and Kanter, 1984). Thus the concept of informed consent has two goals:

(1) to promote and to restore the individual's autonomy; and

(2) to help the patient to understand alternative courses of treatment in order to make an informed decision.

In order to promote the individual's autonomy, treatment decisions must *prima facie* belong to the patient and not the physician and the patient must have both the right to accept and the right to refuse the treatment plan. Second: the patient is an autonomous individual, therefore the patient's decision must be voluntary and free from any sort of compulsion or coercion (see Lidz et al, 1984).

To help the patient to understand the proposed treatment, the clinician must help him to have sufficient access to any relevant information in order to make a reasonable judgement about the suggested treatment. Moreover, the patient must sufficiently understand the presented information. The problem arises when the patient is considered by the psychiatrist as 'incompetent' to understand the information when in a certain psychiatric condition. At this stage, the patient's right to choose between different courses of treatment could be, in very specific cases, shifted and after examining the total function of the patient, to another party (proxy consent). So far, the above discussion reveals the central elements of informed consent. They are as follows:

1. "disclosure of information" (I)
2. "competency" (C)
3. "understanding" (U)
4. "voluntariness" (V)
5. "decision" (D)

(Lidz et al, 1984, p.22)

To summarise, these components could be understood as follows:

"C + I = U

U + V = D" (Ibid., p.23)

Let us now consider the current problem of informed consent in the Psychiatric Hospital in Kuwait by illustrating the following two cases:

Case 1: A Psychotic Patient

K.A., a forty-one year old single stock dealer, was hospitalised following complaints by his family that he was overactive and aggressive, talked irrationally, acted peculiarly, and was trying to commit sexual acts with his younger sister. His psychotic behaviour had developed during the previous year after a breakdown in the stock exchange market in 1982 in Kuwait. His mother called the police because he refused to attend the hospital. The police arrested him while he was driving his car and brought him to the Psychiatric Hospital at 9.00 p.m. The physician in charge decided without the patient's consent or his family's consent to administer largactil 100 mg. intravenously. It required the combined efforts of two nurses to hold the patient down because he refused to be committed.

Although the patient spent two months in the hospital and was subjected to heavy psychiatric treatment (ECT and anti-psychotic medication), the hospital staff did not make any effort to obtain his informed consent to such procedure.

Case 2: A Neurotic Patient

N.K. is a single young woman in her twenties. Her mother called the psychiatrist in charge in the out-patient clinic to send

a car with two nurses to take her daughter into hospital. The psychiatrist sent the hospital car at her mother's request and the patient was admitted to an open ward. During the clinical interview, the patient refused to be admitted claiming that she was in perfect mental health. Her mother, on the other hand, claimed that her daughter was suffering from the following problems: the patient had a history of sexual behaviour with strangers. She used to smoke cigarettes in public. Her last marriage was unsuccessful because her husband discovered that she was not a virgin. Eventually, the family honour was at stake (since her 'immoral' act would consequently affect her sister's future too). The patient was admitted for one month and diagnosed as having a "character disorder". She was given anti-depressant medication and brief psychotherapy. These processes of admission and therapy were conducted without the patient's verbal or non-verbal consent.

It was a common practice for mental health professionals in Kuwait to view psychotic and neurotic patients as irrational and incompetent to give informed consent.

There are certain factors which contribute to the poor conditions of the practice of informed consent in the Psychiatric Hospital. These are as follows:

(1) Out-patient Clinic

The average daily number of out-patients is about 110-115. The way it works is that each unit (5-6 physicians in each unit with

total number of physicians and psychiatrists working in the hospital numbering 39) cover the out-patient clinic for one day a week. That means that each physician will see twenty-three patients a day, each for thirteen minutes. However, the thirteen minutes for each patient have become a luxury and in reality the interview lasts for from 7 to 13 minutes only.

Clearly, there is an absence of the "duty of beneficence" which requires from the physician at least to discover what the patient needs. Moreover, the present services in the out-patient clinic offer no privacy and no respect for the patient. Patients are crowded in a hallway with no decent waiting rooms. The physician cannot arrange to have even minimal privacy with the patient.

What is crucial however, is that it is the junior staff who see the case, reach a diagnosis, prescribe treatment and arrange a follow-up with minimal if any supervision from the senior psychiatrists.

The quantity of work is outweighing the quality. Every patient that comes to the hospital, with or without a previous appointment, has to be seen and nobody is sent back. Therefore, the quality of care offered in the out-patient clinic of the Psychiatric Hospital is inadequate and cannot reflect full regard for the patient's interests and wishes.

(2) For many years psychiatrists in the Psychiatric Hospital in Kuwait have tended to regard the rich and influential psychiatric

patients as fully autonomous, reliable and trustworthy client, and free to decide whether or not to be a patient. In the author's experience, the poor and the disadvantaged, however, are regarded as too dull or too disturbed to know what is best for them.

(3) The Consent Form

The content of the form which is currently in use in the Psychiatric Hospital is very limited and provides no protection for the rights of psychotic and neurotic patients. The same form is used for:

(a) psychotic patients;
(b) neurotic patients;
(c) involuntary hospitalisation procedures;
(d) applying different psychiatric treatments.

This is the original text of informed consent which is currently in use in the Psychiatric Hospital:

Consent for Psychiatric Treatment

_____ Hospital

I _____

fully consent to undergo any therapeutic procedures which may be prescribed by the Hospital doctors including ECT and any related medication. The risks of these procedures have been explained to me.

Signed _____

(Patient)

According to this open and unspecified form of consent, "there is no limit to what the psychiatrist or physician in general can do with the patient if it is considered to be therapeutic" (Back, 1973, p.835). In other words, the patient has no legal protection. Moreover, the law is usually on the side of the doctors.

The consent form is originally proposed in a psychiatric setting in order to provide procedural and legal safeguards against any forms of therapeutic abuse. But in actual psychiatric practice this form has become a meaningless formality with no legislation to enforce the application of the form.

For example, any person could give consent on behalf of the patient. Moreover, in many cases the physician conducts the treatment without the consent form having been signed at all. The fact is that psychiatrists tend to view neurotic and psychotic patients as:

(1) dull and lacking in insight;

(2) ignorant and lacking in status and power. Thus, he must

> "... remain docile and agree to treatment, or it will be forced. He must not question what is being done on his behalf. If he does query this, or attempts to resume personal responsibilities ... or asks to be released before the staff are ready to release him, then his behaviour tends to be seen as further sign of illness, justifying continued confinement" (Berke, 1977, p.23);

(3) incompetent unless this is refuted by his behaviour.

Such presumptions have reinforced the doctors' resistance to the application of the fundamental ethical principles to their psychiatric patients. In addition, such presumptions reflect negatively on the

way patients' records (files) are kept. If we examine patients' files, we will discover that many informative data are missing. Many files contain incomplete history and personal details of the patient, for example, no name, age, address, etc. Medical history is not described in detail, particularly for patients admitted in the early 1950s.

It can also be seen from some of these records that the number of diagnoses made for particular patients could be matched with the number of doctors who have been treating the patient. If the patient has been referred from another hospital, the letter of reference is usually missing and the reason for the referral cannot be found. For patients who were referred by the police, there is nothing documented explaining the reasons (Makkawi, 1982).

The significance of poor record-keeping in the Psychiatric Hospital in Kuwait is very clear. It indicates that most psychiatrists do not appreciate the scientific value of good record-keeping. Good record-keeping, however, is the basis of good clinical care. It is necessary for evaluating the significance of change in a patient's clinical course for judging the efficacy and cost-effectiveness of different treatment methods, for continuity of care, for anticipating what crises may stress patients, and for peer review of quality of care.

The disregard of doctors in the Psychiatric Hospital in Kuwait for appropriate and methodical record-keeping suggests a more

general disregard for the basic humanity and dignity of the patients as well as for appropriate professional clinical practice.

4. Justice and the Allocation of Psychiatric Resources

In clinical practice, economics and psychiatric decisions are closely related. In the implementation of any health plans, clinicians are almost always restricted by the availability of community resources (such as professionals, property, and government public funds) (see Drummond, 1980). In Kuwait, mental illness is a minor concern of the Ministry of Public Health, in spite of its prevalence and its frequently long duration. In Kuwait, the government spends only an insignificant proportion of its health service budget on the needs of the mentally ill people. In 1984, 6.3% of the Kuwait total national budget was allocated to public health. This represents 167 million KD. Of the above, 4.5 million KD or 3% was directed to the psychiatric and mental health services in Kuwait (Al-Ansari, 1985).

In most European and North American countries, psychiatric care costs 10-15% of the total expenditure on public health. This represents 3-5 times of what is available and spent on psychiatry in Kuwait (Ibid., 1985).

In the past ten years or so, the population of Kuwait has increased by 50%. In correspondence with this there was only a 10% increase in beds available for psychiatric care and, what is more serious, a zero increase in the number of physicians practising psychiatry. The hospital wards which were designed to accommodate

24-28 patients are presently packed with 30-32 patients, many of whom sleep on mattresses stretched on the bare floor. An average size room is occupied now by eight and sometimes more patients who could be extremely hostile, combative and seriously disturbed. This has resulted in the trend to discharge patients prematurely.

But perhaps the most shocking practice is the way and process in which people with mental illness are labelled. The resulting stigma and shame of such labelling might lead society to deal with the labelled individual as not valid human and to treat them as second-class citizens (Siegler, Osmond and Mann, 1972).

Moreover, the Psychiatric Hospital in Kuwait is considered to be a morally justified method that releases the patient's family from the social shame and guilt induced by incarcerating its members for many years. It is for such reasons that some families refuse to give their address to the hospital's authorities or just bring the patient to the hospital and disappear. This is because the patients' families are anxious about mental illness and feel guilty about their involvement.

TABLE 2: Comparison of Characteristics of Long-stay Patients in Mental Hospitals in the United Kingdom, Sri Lanka and Kuwait expressed in percentages (1981)

Country	% of total hospital population	Civil state single on admission			Known next of kin	Visited once per year	Diagnosis - schizophrenia
			Male	Female			
U.K.	40.0	70.0	46.0	54.0	69.0	57.0	50.0
Sri Lanka	18.0	67.0	53.0	47.0	60.0	26.0	79.0
Kuwait	28.7	55.6	49.7	30.9	27.0	54.9	77.4

(Source: Mackkawi, 1982, p.5)

Unfortunately, the attitudes of the families towards mental illness are supported by those of the professionals who view mental disorders as something permanent with a long-lasting personality defect rather than a passing problem. For that reason, many mental patients (approximately 70%) stay for very long periods of time in the hospital even though the services for the mentally ill are underfunded and in the very worst of conditions. The politics of such beliefs are very clear. If the mental disorder is a long-lasting or permanent tendency, and if the problem is viewed as residing inside the individual, then there is little point in increasing health funds or developing psychiatric facilities.

According to Szasz (1973a), "... Psychiatry has accepted the job of warehousing society's undesirables ..." (p.83) rather than providing them with an effective short-term psychiatric intervention or real medical treatment. On the comparison between medical hospitals and psychiatric hospitals, he states (1984b) that:

> "Real hospitals, that is medical hospitals, especially the good ones, often have more doctors than patients! But mental hospitals are fake hospitals, hence they do not need any doctors at all (except perhaps a few consultants to come for the medical needs of the otherwise medically healthy population." (p.77)

Although Szasz is a pessimist, he is partially right in his claims. The problem is that Kuwait is seriously short of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. In the author's experience, only 15 qualified psychiatrists and about 20 general physicians (not qualified psychiatrists) are currently working in the Psychiatric Hospital. The general physicians are allowed to administer psychiatric medication, practise psychotherapeutic sessions without any previous training in psychotherapy. Moreover, they can apply certain forms of psychological tests and make decisions on the basis of these tests, also without any adequate training.

In addition, there is a serious lack of different treatment modalities. That is to say, psychotherapy, behaviour therapy, and rehabilitation programmes are still regarded just as "myths". In brief, the present structure, space and arrangements in the Psychiatric Hospital in Kuwait are totally inadequate.

Conclusions

Development in the psychiatric services in recent years in Kuwait shows that mental health professionals have not travelled far beyond the walls of the old "asylum". Many psychiatrists tend

to regard hospitalisation as a treatment in itself, and have accepted the job of "warehousing society's undesirables". For that reason, most psychiatrists in Kuwait think that compulsory treatment is more important for a patient than his freedom. As a result, a variety of moral and ethical problems arise.

In summary, the quality of care, the diagnostic processes and the management of psychiatric patients in Kuwait should be seriously questioned. The Kuwaiti public and media, especially newspapers, have consistently raised questions regarding the moral justification of many forms of professional malpractice and incompetence. Such practices, however, have received little official investigation.

For example, there have been a certain number of psychiatric patients in Kuwait who have died under ECT therapy. The author's personal experience with such incidents is that these patients died because in some cases the 'psychiatrist' in charge was not qualified sufficiently or did not have enough time to read the patient's ECG.

Other common stories that have appeared in the press in Kuwait are about nurses or doctors who beat patients or commit sexual intercourse with some female patients. Unfortunately such cases have received very little attention.

What will be our concern in the next few chapters will be to provide a more global analysis of the concept ot mental illness

in order to see how such a concept is open to abuse from the psychiatric profession and what the moral consequences of such abuse are on people described as mentally ill.

CHAPTER TWO

THE CONCEPT OF MENTAL ILLNESS: WEAKNESSES AND LIMITATIONS

THE CONCEPT OF MENTAL ILLNESS: WEAKNESSES AND LIMITATIONS

Introduction

If one tries to analyse the current definitions of mental illness in textbooks in clinical or abnormal psychology, one would easily discover an apparent disagreement between the authors on how to define the concept of mental illness. That is due to the fact that the definition of mental illness is closely tied to the different models of mental illness adhered to by psychiatrists or psychologists. The psychoanalyst would define mental illness in terms of a defective development of the ego or fixation or repression or other psychoanalytical terms. The behaviourist, on the other hand, would define mental illness in terms of negative learning habits. Clinicians who adhere to the social school would define mental illness as the result of environmental factors such as: labelling the individual, the societal and familial pressures placed on the individual, or the general disturbance in the individual's social role, or social stereotyping of the concept of 'insanity' which helps to maintain the status quo of being mentally ill (Goffman, Scheff, Rosenhan).

Finally, the medical model would define mental illness as a significant 'clinical' abnormality which is due to organic defect in the individual patient and although such a defect has not yet been established in most mental disorders, the adherent to this model works on the assumption that such a defect will be discovered in due time.

However, the belief that psychiatrists have infallible scientifically and medically proven methods of definition and

classification of mental phenomena has given way to the unsettling knowledge that judging a person is a delicate process which entails conflicting perceptions, individual feelings as well as social interaction and professionals' opinions that could be based on vague, ill-defined codes or criteria.

Of course, that is not to say that scientific certainty would solve the negative moral consquences which resulted from labelling people as mentally ill. The influence of psychosocial factors involved in the process of being mentally ill is often difficult to measure by using 'scientific' procedures. Moreover, we need to be aware of the psychological impact of such labels on the individual and his standing in society.

The dangers implicit in the labelling of people as 'mentally ill' can be appreciated when one considers the following consequences: Firstly, the general assumption that mental illness can diminish the patient's ability to think rationally and autonomously can lead to serious devaluation and diminution of the rights and responsibilities of the labelled individual (Wear, 1980; Edwards, 1982). Secondly, the very label 'mental illness' can cause the patient to develop negative feelings of 'helplessness' and 'hopelessness' and can also create pessimistic attitudes among the helping professionals, which, in turn, may hinder any therapeutic efforts in the future (Rimm and Somerville, 1977).

Moreover, definitions of the term 'mental illness' are in many cases, unclear and inaccurate, and social, political and institutional factors rather than clinical ones might be involved in the assessment of persons as mentally ill (Mechanic, 1967).

Rimm and Somerville (1977) consider that the label 'mental illness' is 'socially stigmatising' and not a 'humanitarian act'. They state:

> "In truth, it is kinder to label someone as mentally ill than to pronounce him guilty of witchcraft and deserving of torture. But in a culture that no longer believes in witchcraft, branding an already troubled person with an ill-defined label that provides little real information and is socially stigmatising is hardly a humanitarian act." (p.44)

It is the main purpose of this chapter to consider the following points:

(1) the value of professional and scientific approaches to mental illness as represented by the current diagnostic schemes in psychiatry;

(2) the limitations and weaknesses of the concept of mental illness. It must be made clear at this point that the arguments developed in this chapter concern borderline cases which do not represent clear-cut text-book symptoms of mental illness;

(3) what a definition of mental illness should incorporate;

(4) the validity of the concept of mental illness and its limitations.

Throughout this chapter, the concept of 'illness' rather than 'disease' will be used. The problems with these terms have continued to pose many controversial questions regarding the validity and reality of cases described as in a state of 'disease' or 'illness'. From a careful examination of the current psychiatric writings, one would notice that there are no universally agreed definitions of the above concepts. Most 'naturalist' writers in this subject such as Moore (1981), Spitzer (1978), Kendell (1981), Taylor (1981), Freidson in Miles (1981), etc., believe that the concept of disease is basically comprehensible in terms of physiological defect - the so-called "medical model". 'Illness', however, has been viewed as a psychosocial condition that is related to a disturbance in the expected role-performance or disvalued conditions that have undesirable effects on the patient's behaviour and adaptation which render the conditions more observable. At this point, the individual's 'illness behaviour' (Mechanic, 1981) is considered to be not-responsible (socially excusing). Some writers such as Engle (1981) emphasize the importance of the individual experience of the organic failure (the disease condition) in determining the reality of 'illness' condition or feeling 'ill'. Accordingly, Engle maintains that it is difficult to separate 'illness' behaviour from 'disease' condition. However, both psychosomatic illness and a symptomatic disease, represent a significant separation of illness from disease and are arguably very common.

Another group of writers such as Margolis (1978) and Englhardt (1981) have argued that the concept of disease and illness are basically related to values. Thus, functioning is more culturally

determined (good or bad function). That is to say, these writers' approach is basically normativist in that the societal attitudes might value or disvalue the disturbed function.

Radical psychiatrists such as Thomas Szasz, R.D.Laing, etc., emphasize that observable physiological failure is a necessary and sufficient condition for the presence of 'illness' or 'disease'. Fabrega (1981) on the contrary, believes that neither disease nor illness "logically entail an understanding of bodily function" (p.498). That is because both illness and disease refer to perception or evaluation of the disability in general medicine and disturbed social relationship or disturbed beliefs in psychiatric disease.

Now, before trying to see how the concept of 'illness' or 'disease' fits psychiatric conditions, one must ask the following question: are the definitional problems of mental phenomena and psychiatric abuse basically tied to either the 'disease' model or the 'illness' model? Would adherence to either the naturalist approach or to the normative approach solve the problematic nature of psychiatric practice?

It will be argued throughout this thesis that the definitional problem of mental conditions and psychiatric abuse is not crucially related to which of these terms ('illness' or 'disease') mental health professionals adopt. The problem stems basically from the set of thoughts and beliefs which centre around the concept "mental", and the metaphysical background of many mentalistic vocabularies. Thus, by

arguing that the problems of psychiatric daily practice are basically related to the concept of 'illness', one might think that adopting the concept of 'disease' will solve the problem. Unfortunately, this is not the case. Moral and practical problems in the management of schizophrenia, for example, may arise either from a conception of 'disease' as a result of genetic factors, or from a conception of schizophrenia as merely third party labelling. That is to say that it does not make much difference from the moral and practical point of view to say that schizophrenia is disease or illness. That is because the very use of the term schizophrenia can create a certain set of negative ideas such as diminished responsibility, irrationality, madness, not being fully human, etc. However, just because the connotations of the label 'schizophrenia' are so negative, this does not mean that we can negate the very reality of schizophrenia. Nevertheless, the sort of explanation we choose (either genetic or social) makes, in the long run, little difference in terms of the negative moral consequences of the label 'mental illness'.

The present writer's main argument is that there are certain unobservable factors that contribute to the continuity of the problems that surround the definitional and moral aspects of psychiatric practice. Such hidden factors (in the definition of mental illness), i.e. social, political, psychiatric, etc., will be discussed in detail throughout this chapter.

Despite our assumption that a choice of terms (either 'disease' or illness) has little bearing on the moral and practical consequences of being labelled, one does need, for the sake of

clarity, to specify what is meant here by the concept of 'disease' and 'illness'. Throughout this thesis, the concept of 'disease' will refer to agreed biological abnormalities that - in Moore's (1978) terms - "lie behind the behaviour". The individual psychological reaction, his subjective experience of the 'diseased' condition and the societal reaction to such experience would refer to the "illness condition" or "illness behaviour" (Mechanic, 1981).

Clearly, as many psychiatric conditions do not have an observable biological basis and the definition of an individual's suffering are basically related to his thoughts and behaviour, our discussion, accordingly, will be tied basically to the concept of illness rather than disease.

The definitional problem:

Consider the following two cases:

Case 1

> On October 5th, 1960, Mrs. Anna Duzynski, a recent Polish emigrant who lived with her husband on the northwest side of Chicago, discovered that $380 in cash had been stolen from her apartment. Suspecting that the money had been taken by the building janitor, the only other person who had a key to the apartment, Mrs. Duzynski rushed to his flat and demanded that the money be returned. The janitor in turn called the police, and upon their arrival stated that both Mr. and Mrs. Duzynski were insane and should be committed to a mental institution. Without any further examination, the police seized both Anna and Michael Duzynski, neither of whom spoke English, and took them in handcuffs to the Cook County Mental Health Clinic. At the Mental Health Clinic, unable to answer questions in English and thereby defend themselves, the Duzynskis were duly pronounced mentally ill and committed to the Chicago State Hospital. Six weeks

> later, Michael Duzynski still had less idea why he had been imprisoned than he had when thrown into a Nazi concentration camp in World War II. Finally, in desperation, he hanged himself. The gross injustice of the entire affair thus vividly pointed out to them, hospital officials hurriedly released Anna Duzynski the next day. (p.41)
> (The case cited in Rimm and Somerville, 1977)

Case 2:

> The case came to my notice over fifteen years ago when many of the methods of treatment we now have were not known. Mr. D was 67 years of age. A retired civil servant. A man of great piety who devoted his retirement to prayer and works of charity. His wife had no sympathy for what she regarded as a morbid religiousness. One morning at mass, he heard read the words of the Gospel 'go and sell all that thou hast and give to the poor, and thou shalt have treasure in Heaven, and come and follow Me'. These words spoke to Mr. D like a command. And straightaway he left the church, putting all the money that was on him into the poor-box at the door. He set off to walk the 135 miles to Lough Derg, a famous place of pilgrimage in Ireland since earliest times. When he did not return for his breakfast and the morning passed without news of him his wife became alarmed and notified the guards. Eventually, that evening he was stopped by a police-man of a small village about thirty miles from Dublin. He was seen by a doctor and put on a temporary cert-ificate for admission to a mental hospital. He made no protest at entering hospital, told his story clearly, and accepted what had happend as God's will. I informed the medical superintendent next morning that we had admitted a saint.
> (Drury in Clark and Winch, 1970, p.91)

Drury was doubtful whether that particular man was in need of diagnosis at all, as his only wish had been to give his money away to the poor. For the sake of argument, our analysis of Mr. D's case throughout this thesis would be based on the assumption that the psychiatrist in charge admitted him in the belief that the case is presumably suffering from a certain kind of psychosis, i.e. paranoid schizophrenia.

We shall shortly imagine a hypothetical situation where a psychiatrist from Kuwait (representing the third world) and Robert Spitzer (chief physician who chaired the task force of DSM-III) representing the Western world has to decide the normality of the above two cases. But before doing so, let us examine three systems of diagnosis and definition of mental illness which are widely accepted throughout the world.

Let us first consider the definition of "mental disorder" which was developed by the DSM-III-R (Diagnostic and Statistical Manual of the American Psychiatric Association, 1987):

> "Mental disorder is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g. the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the person. Neither deviant behaviour, e.g. political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction in the person as described above."
> (DSM-III, p.401)

The members of the task force of DSM-III are hoping to publish the new edition of DSM-IV by 1992 (Psychiatric News, April 15, 1988).

ICD-9 (International Classification of Disease) has developed the following definition of mental illness:

> "Psychoses - mental disorder in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. It is not an exact or well-defined term. Mental retardation is excluded."

The WHO has completed its preparation to launch the new edition of ICD-10 in 1991. The new ICD-10 will be much longer in order to cover a wide range of mental disorder (Jablensky and Cooper and Burke, 1988).

In a related attempt to define mental illness, the Department of Health and Social Security in England in Heginbotham (1982) suggested that mental illness means having one or more of the following characteristics:

(1) a more than temporary impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity;

(2) a more than temporary alteration of mood to such degree as to give rise to the patient having a delusional appraisal of his situation, his past or his future, or that of others, or the lack of any appraisal;

(3) delusional beliefs, persecutory, jealous, or grandiose;

(4) abnormal perceptions associated with delusional misinterpretation of events;

(5) thinking so disordered as to prevent the patient making a reasonable appraisal of his situation or having reasonable communication with others. (p.4)

It can be seen that both the DSM-III and ICD-9 state necessary, but not in themselves sufficient, conditions on which the individual can justifiably receive the definition of mental illness or be deprived from his basic freedom throughout compulsory detention (Farrell, 1985). None of the above three systems of definition provides an operational definition for mental disorder. That is because they require systematic conceptual perspectives and highly reliable criteria for judging the abnormality of any given condition. Moreover, the "family resemblance" of each form of mental disorder in a "family grouping" cannot be identified or represented by a list of "defining properties" and the causal consequences of the disturbed condition are governed by vague and unspecific explanations (Farrell, 1985). Throughout this chapter, we will argue that this absence of 'defining properties' has contributed to the existence of continuous difficulties in terms of a lack of a clear and systematic method in relating symptoms to certain 'psychopathology'. As a result, the interpretative methods of the symptoms presented would depend mainly on the subjective impression of the psychiatrist rather than on the reality of the individual's actual symptoms of suffering. The DHSS definition, on the other hand, although more extensive in nature, incorporates in its view of mental disorder terms such as "delusion", "thinking disorders", or "hallucination", or "loss of contact with reality", which are open to an unlimited number of interpretations as we shall see later (Heginbotham, 1982).

Now let us imagine the hypothetical views of our representative psychiatrists. Mr. D, for example, would be defined by the

Kuwaiti psychiatrist as a normal good citizen because he didn't violate any culturally defined norms (Scheff, 1971). Helping the poor, even to this extreme degree, is a positive characteristic that is highly valued in Islamic countries.

Robert Spitzer would certainly view Mr. D as unintelligible and lacking a meaningful content to his life. Cases such as Mr. D are traditionally viewed by psychiatrists as irrational, irresponsible and unpredictable. A couple of hundred years ago, Dr. Spitzer would speak of Mr. D or Mr. Duzynski 'as if' they had lost their mind; then the metaphor 'as if' was projected on the body. But then, Spitzer drops the 'as if' and starts to believe that the act of spending behaviour or the inability to speak the English language is not 'as if' insanity, but something that can be treated and defined in the same class as fever, that is, a symptom (Sarbin, 1967). The metaphor 'as if' seems to have become 'real'. Thus, Spitzer would not hesitate to state that the concept of mental illness must be viewed as a subset of medical disorders.

In psychiatric practice, there are many 'as if' metaphors. In the DSM-III implicit definition of mental disorder, a person is considered to be mentally ill or vulnerable to mental illness if he shows certain signs of 'distress' to himself or to those around him. However, the application of the criteria of 'distress' can be rather loose and vague. As a result, the psychiatrist would be totally free to ascribe 'distress' to any form of behaviour he sees fit (Moore, 1984). Thus, Mr. D is in a distressed state because

his spending behaviour annoyed 'others' and was considered to be a serious breach of the general expectations or socially fixed norms or about the degree of acceptability of the act of helping the poor that is held in a given society and considered to be normal.

Another example would be the concept of 'disadvantage' as used by Spitzer in his definition of 'mental disorder' in the DSM-III. The use of the term 'disadvantage' was aimed to "allow the adverse reaction of society to count as placing the individual at disadvantage" (Moore, 1984, p.213). Thus, Mr. D's spending behaviour which incurred the anger of his family, could be viewed as placing him at a 'disadvantage' and thus as pertaining to the category of 'mental disorder'. On the other hand, if the family or society in general shows little or no concern to such 'over-spending behavior' then no negative consequences would have occurred and Mr. D would not have been placed in the 'disadvantaged' category and would not have been defined as mentally ill. Mr. Duzynski, however, did not show any sign of distress or being in a disadvantaged state. For Spitzer, even an individual who fails to meet the three D's (distress, disability, and disadvantage) still may not be free from mental disorder, for he may be 'vulnerable' to the disease condition. That is to say that, although Mr. Duzynski's case represents an extreme form of psychiatric practice, it does indicate that factors which are central in the identification of mental illness are not always based on the individual's actual suffering or complaints (the role of non-clinical factors in the diagnosis of mental illness will be discussed in detail as the chapter progresses). The alternative is that the

term 'mental illness' may be used in a 'demeaning fashion' and those who are so labelled may be treated as if they have a general trait of incompetence (Sarbin in Rimm and Somerville, 1977). The above discussion shows clearly the slippery nature of the concept of mental illness.

It could be argued that almost every aspect of human behaviour or human thought could be interpreted as evidence of 'mental illness' or a sign of incompetency or vulnerability or potentiality to illness. Thus, a decision to travel on foot for a few days could be taken as evidence of the 'Fugue' dissociation neurotic symptoms (Haas, 1979). 'Deep imagination' becomes 'withdrawal', which is considered to be "a violation of customary expectations about the degree of social and interpersonal distance that is held in the society ..." (Scheff, 1975, p.18). Showing sympathy for the poor (as in Mr. D's example) becomes a sign of delusions. Not speaking the English language becomes a sign of confusion or bizarre thoughts or lack of insight. Having an active social life becomes a sign of 'manic disturbance'. Deciding to play cards in a casino three times a week might be taken as evidence of 'pathological gambling'. (For more examples, see Scheff in Shean, 1971, and Smith, 1982.)

The above examples show clearly that society or the family can cause the patient to be alienated from himself and others which helps them to shift the moral blame from themselves to the patient and to justify and rationalize all psychiatric procedures carried out on the patient (Laing in Smith, 1982) in the name of good mental health or the patient's best interest.

Laing's argument shows rather conclusively the confusion between the criteria on which psychiatrists should base their decisions, i.e. objective observable criteria, and the subjective factors or non-psychiatric influences (Cocozza and Steadman, 1985; Marson et al, 1988) which actually influence their decisions.

The above discussion suggests that it is very difficult if not altogether impossible in the mental health professions in general to draw an objective and unbiased line between the effects of social or non-clinical norms such as, the family, perceptions of the 'patient', previous history of hospitalisation, institutional norms of adjustment, or other factors such as the clinician's motivation to resore the patient's autonomy, or to protect the patient or others, future dangerousness, etc. (Mendel and Rapport, 1969; Marson et al, 1988) and those of clinical norms, i.e. actual complaint of the individual as expressed by independent organic indices.

Consider, for example, the kind of institution the psychiatrist works in. If he works in a public mental hospital, for example, where the general expectation is to diagnose and admit patients, the psychiatrist in such an environment is more likely to reaffirm the public or lay definition of what counts as a symptom of mental illness. If the setting is a court, however, the psychiatrist is likely to be motivated to prove or to disprove the reliability of the offender's claims of abnormality rather than to provide an effective treatment or 'helping' plans.

The above limitations of the psychiatric definitional system had led many writers such as Laing (1960), Szasz (1972, 1973, 1984, 1987), and Leiffer (1969), to question the value-'neutrality' of psychiatric definition of mental illness.

Leiffer alongside with Szasz notably, puts great emphasis on the fact that the central function underlying the practice of psychiatry is social rather than medical. Both writers reject the definition of human psycho-social problems within the disease or medical model and believe it belongs within the structure of social or ethical life. The consequences of the medical mask of psycho-social model, as Leiffer (1969) puts it, is that "it permits social authority to mask itself with scientific credentials and scientific credibility" (p.83).

As a result, it is not surprising to discover that many political principles, religious beliefs and personal values could be viewed as belonging to the category of the inappropriate, or as outside society's standard forms of thought or behaviour, and thus meriting the term 'mental illness' (Edwards, 1982). For that reason, psychiatrists today turned out to be "... the most powerful section of society which will be able successfully to define what is undesirable conduct and what is the less favoured life-style; and they will be able to control, in the name of good health, those who offend against their definition (Miles, 1987, p.209). For that purpose, the terms "adjustment or adaptation or fitness to society" which are derived basically from the Darwinian biological principles of

adaptation and maladaptation (Schwab and Schwab, 1978), have been used in current psychiatric manuals as central criteria for 'mental health'. Thus, when the individual's behaviour does not conform to a society's norms of adjustment, psychiatrists, representing the social system, interfere to 'reform' their behaviour so they can be made to fit or adjust to society's norms (Bloch and Reddaway, 1977; Scheff in Gove, 1982; Scheff, 1971). Thus, not being able to adjust to society's stereotypical values would imply or assume certain deviation from a standardised adaptive norm in the same way a deviation from biological norms would be believed to be. The only problem, however, with the diagnosis and classification of mental disorders is that it relies heavily on a vague and unspecified norm of adjustment, employed by the clinicians (Livermore et al, 1968). The problem on a large scale stems from the fact that the concept of mental illness as applied in psychiatric daily practice is much more closely related to the individual's personal systems of values because it seeks mainly to define and make sense of that most intangible area, i.e. thoughts, social interpersonal relationship, systems of feeling, and emotions. The morally significant concern of the above point is that any attempt to define the individual's functional behaviour would provoke many problematic moral issues. Mental competency, a term which continues to pose many methodological and evaluative problems in psychiatric daily practice, is often assumed by the psychiatrists as a necessary qualification for maintaining the moral and social agency of the patient within the community. The problematic issue of the application of mental competency criteria in deciding the moral reliability of a given individual is the nature of methods

which the psychiatrist in general uses to define mental competency. That is to say that the psychiatrist's definition of the individual's validity is a summary of his personal values, society's norms, institutional ideology and the general principles laid down in a given diagnostic manual. In other words, the psychiatrist when confronted with a patient, is indirectly comparing himself with the patient's general attitudes or total functioning. The question he (the psychiatrist) (subconsciously) asks himself before establishing his primary diagnosis is: What are the similarities and differences between my attitudes and the patient's attitudes?

A simple answer to the above question, which most psychiatrists would undoubtedly reach, is that their own attitudes reflect the most acceptable norms of conduct and thinking which every individual in society is supposed to hold.

Any deviation from such rules would lead to the assumption that the deviating individual "... cannot be trusted to live by the rules agreed on by the group. He is regarded as an outsider" (Becker, 1973, p.1). However, one cannot readily accept the idea that psychiatrist in general have the right to determine what kind of values a reasonable patient should have, even when the individual "... lacks the capacity not the will" (Edwards, 1983, p.200) to be a full prima facie rational agent.

Thus Laing, among others, believes that to define the individual's attitudes and behaviour as irrational is to deny his

basic sense of responsibility and his moral agency. For Laing, what appears to us as bizarre or unintelligible, in reality has a meaning, motive, and content. It represents methods of adaptation to stressful situations. Such adaptation, for Laing, reflected the patient's experience and the characteristics of the situation he finds himself in. A crucial problem in psychiatry, Laing maintains, is basically related to the denial by most psychiatrists of the patient's thoughts, feelings and experience.

Clearly, Laing like many other radical psychiatrists gives the patient's values, his unique experience, and his ability to decide between different courses of alternative action, precedence over the psychiatrist's or society's values. For such psychiatrists, there is no specific standard that can be established for an accurate understanding of the patient's ability to make autonomous and sound choices. Many other writers such as Lavin (1985), Ingleby (1981), Livermore et al in Macklin in Chaplan et al (1981), Lazarus (1975), Slavney and Mchugh (1987), Leff (1986), Gove (1982), Light (1982), etc., have voiced similar doubt concerning the subjectivity of criteria in psychiatric judgement, especially in determining what is mental health or what should characterise a healthy attitude towards life, etc.

Our main emphasis in this chapter will be the effects of subjective factors on clinical decisions. Such concern emerges from the fact that the presence of arbitrary and non-clinical decisions have resulted in the creation of conflicting and multiple definitions

of what is the ideal or most appropriate mental health or healthy attitude or well being. Accordingly, the same person might be labelled mentally ill according to certain norms in certain circumstances, while viewed as mentally healthy according to a different set of norms (Macklin, 1981).

If we consider, for example, axis v ("highest level of adaptive functioning in the past year"), (Quick Reference to the Diagnostic Criteria from DSM-III, 1980, p.16), the psychiatrist must estimate in objective method the patient's highest level of adaptive functioning in the past year. According to the DSM-III's manual instructions, such evaluation would have a significant prognostic and diagnostic value, because usually the individual patient returns to his past level of adaptive functioning after the onset of illness (Fernando et al, 1986). Accordingly, the diagnostician is responsible for deciding on the patient's behalf, what is an adaptive functioning and how his behaviour differs from or is similar to that of an "average" person (Davison and Neale, 1986). Thus, instead of examining the 'patient' himself, the psychiatrist rates the severity of his problem to the standard reaction to the same stressor from an "average" person. What if both the clinician and the patient disagree or differ in their definition about the meaning or contribution of the stressor? (Williams, 1985). As Taylor in Davison and Neale (1986) and Roth in Fernando (1986) argue, the psychiatrist's definition concerning the patient's level of adaptive functioning refers crucially to his own personal values and subjective meaning about how a normal person should function at a specific time in his life and in specific

conditions. (e.g. A man should not smile while attending a funeral.) Surely, that leads us to emphasize the fact that the concept of mental illness involves a pre-determined set of norms such as that the patient's feelings are "inappropriate", he is "unable to be involved in an effective human relationship", he has "disorder of thoughts", or "withdrawal". The above description of the individual's functional disturbance presupposes or assumes a culturally agreed standard concerning the appropriate limits of, for example, friendship or what are acceptable rational thoughts or the amount of acceptable emotional and behavioural distance between the 'patient' and his social reference group. Deviation from the above standards or ready-made societal norms would lead to the diagnosis of mental illness (Scheff , 1971; and Scheff, 1975).

In many cases, such societal values represent a hidden but central hypothesis which determines the diagnosis of abnormality of any given individual which in many cases takes precedence over the severity of the symptoms (see Macklin, 1981). In this way, the diagnosis of mental illness is irreversible as no independent diagnostic indices or psychological tests have yet been developed to determine objectively the presence or absence of mental disturbance. As social or family values determine psychiatric definition (Greenley, 1975) alongside the presence of inner unverified explanatory methods of abnormality, it would be very difficult to conduct the necessary observation of the manifestation of illness. As a result:

> "Psychiatric diagnoses, unlike those in other branches of medicine, are almost irreversible. Internists, neurologists, and pediatricians sometimes have to admit errors, but a psychiatrist never does; it is not he who was remiss, but the schizophrenia which is in remission .....
> A medical diagnosis is much like a hypothesis in a science; it should lead to further predictions and be subject to disconfirmation. In science, hypotheses that cannot be disproved by any conceivable evidence are not hypotheses at all. Should we not conclude that diagnoses which cannot be disproved are equally meaningless? By showing that the diagnosis of schizophrenia is essentially irreversible no matter how the patient subsequently behaves, Rosenhan has dealt the scientific pretensions of psychiatry a serious blow.
> (Neisser in Scheff 1984, p.193)

In fact, a careful evaluation of the definition of 'mental disorder' listed in DSM-III, for example, would reveal that the manual conceives mental functions as something that can be easily observed and isolated in a control clinic environment for the purpose of testing, "... each of the mental disorders conceptualized as a clinically significant behavior ..." (DSM-III, p.401) or as something that has a recognised clear-cut set of norms, "pattern that occur in a person" (Ibid., 1987). That is to say, most manuals and definitions of mental illness are worded in a way which gives a strong impression to lay public and health professionals, that diagnosing a person as mentally ill is an objective clinical process which involves specific symptoms of a specific disease for which the psychiatrist possesses a well-established and specialised knowledge in this subject (Schacht, 1985; Szasz, 1987; Millon, 1983; Sarbin, 1967 and 1969). In fact, "the DSM-III implies the existence of a world in which control, clarity, and certainty about classifying mental disorders is possible and hence, expertise about these matters is also possible" (Schacht, 1985, p.515).

In reality, the individual's mental functions and his personal experience cannot be specified in terms of absolute categorization and this makes it difficult, if not impossible, for mental health professionals to establish acceptable and precise boundaries where normal mental functions end and abnormal functions begin (Nathan, 1980; Macklin, 1981; Roth and Kroll, 1986). Depression caused by external causes, for example, such as work problems or exam anxiety, which is very normal, is difficult to distinguish from depression that arises from floating anxiety or general mental instability. The crucial question that follows concerns the ability of psychiatry to decide when the individual's behaviour or mental experience deviates significantly from the acceptable norms to certify its designation as 'illness'. What is more, who can decide, authoritatively, what kind of adjustment or behavioural norms are acceptable as criteria of health? (Roth and Kroll, 1986).

Thus, bearing in mind our previous discussion on the presence of subjective criteria in psychiatric diagnosis, one has to face the fact that violation of "communal expectations" (Weinberg, 1978, p.25; see also Pflang and Rohde, 1970) of functioning in certain norms seems to be the basic criterion of healthy or unhealthy personality. For this reason, a great deal of emphasis needs to be placed on the uniqueness of the mental patient because:

> "Understanding the uniqueness of the reality of each person is the very essence of psychological skill, skill that must deal not only with individual variance but with the person's shifting subjective state."
> (Weinberg, 1978, p.27)

However, in practice, such psychiatric "skills" are difficult to apply. This is because, in reality, many individual cases would receive the definition of mental illness on the basis of administrative rather than clinical considerations (Mendel and Rapport, 1969).

The point that must be considered in this respect, is that the basic administrative component in the psychiatric definition of mental illness is the third party claim, i.e. the community members. That is to say that:

> "The basic decision about illness is usually made by community members and not professional personnel. Although the very 'sick' are usually found in mental hospital, there are occasions when very 'sick' persons go unattended while moderately 'sick' persons receive treatment. This selection is clearly based on social criteria, not on psychiatric ones ..... community persons are brought to the hospital on the basis of lay definitions and once they arrive, their appearance alone is usually regarded as sufficient evidence of 'illness'."
> (Mechanic, 1967, p.27)

Clearly, the definition or classification of the mentally ill could be made by the 'patient's' family (as in the case of Mr. D), his colleagues, his relatives, the police (Duzynski case), etc. The problem is that by putting a label or a name on some class of 'disturbed behaviour' or 'bizarre experience', psychiatrists think that they have actually understood the labelled condition. In fact, such understanding would be no more than a myth. Such labels do not describe the patient's subjective experience or the content of his thoughts or disturbance. A phobic "fear of open spaces may not prevent the mother of a young baby from caring adequately for her

child within the walls of her home: but if it later interferes with being a good mother to school-age children the phobia will be regarded as more serious because more disruptive" (Miles, 1987, p.32).

Not being able to understand or to appreciate the nature, meaning, purpose, and content of the mother's phobia of open spaces and the 'patient's' ability to function socially in spite of her suffering, would incline many psychiatrists to interpret her single and temporary disturbance as an indication of a more serious 'mental disturbance' (ibid., 1987). That is because, in many cases, mental health professionals seek to apply standards of abnormality which could be best viewed as 'problematic'. That is to say that clinicians, in many cases, believe that maximum rationality is a necessary condition for mental health and ignore the fact that people are liable to some irrational thought and behaviour in their daily life which is accepted as quite normal. Similarly, Goffman, throughout his book "Asylum, 1960", describes the non-professional or non-psychiatric involvement in the definition of mental illness by stating that:

> "... a psychotic man is tolerated by his wife until she finds herself a boyfriend, or by his adult children until they move from a house to an apartment; an alcoholic is sent to a mental hospital because the jail is full, and a drug addict because he declines to avail himself of psychiatric treatment on the outside; a rebellious adolescent daughter can no longer be managed at home because she now threatens to have an open affair with an unsuitable companion, and so on." (p.129)

For Goffman, such "social contingencies" which can determine the patient's future well-being can play a central role in the psychiatric decision to admit or discharge the patient. The problem is that the third party claim is not a well-founded interpretation of the individual's presumed suffering or distress (Wing, 1978). Such social contingencies and the third party claim alongside the presence of vague and unspecified factors which are not always medical in nature, have led to the conclusion that Mr. Duzynski and Mr. D must be mad.

In other words, the definition of mental illness is, in many cases, unconnected or vaguely related to the actual symptoms presented by the patients in the sense that if, for example, the psychiatrist empathises with the above 'cases' or is influenced by their social status, he is likely to label them as neurotic or suffering from personality disorder, etc. But if the psychiatrist fails to establish basic empathy with the patient and he finds it difficult to understand what factors are involved in the problem, the patient might be labelled as 'psychotic' (Light in Gove, 1982; Mechanic, 1967). For example, in the psychiatric hospital in Kuwait there is a basic tendency among psychologists to characterize Bedouins as untidy, scruffy people, with an unpleasant body odour due to lack of personal hygiene and as lacking in socially acceptable 'civilized' behaviour. Thus, inevitably, when interacting with such people, the psychologist is influenced by his negative attitudes and prejudices with the result that he would rarely listen carefully or take seriously what the Bedouin patient is saying. Such psychologists might even be convinced

that the Bedouin patient is mentally retarded before any tests have been applied. Some mental health professionals even go so far as to give an I.Q. score to such individuals without ever conducting the appropriate tests. They justify such actions on the grounds that the physical appearance and overt behaviour of the patient indicate that he is 'dull' or 'mentally retarded'.

Thus, there is often a proneness in many cases for the clinician to depend on his subjective impressions of the patient's behaviour when making a diagnosis. Szasz (1987) put it convincingly when he stated that there is a basic confusion and a gap in the psychiatrist's decision between his subjective view of the individual patient (as someone who is irrational, unpredictable, and thus invalid) and the disturbed condition in itself as something 'objective' which must be considered as unconnected with the pre-determined subjective norms.

A careful analysis of current psychiatric practice in Kuwait would reveal that psychiatric definition of the presented problem is largely based on one or two basic features or symptoms (see Costello, 1970). Duzynski would be considered by a Kuwaiti psychiatrist as "a typical psychosis" due to the presence of 'word salad' of a duration less than two weeks. The reason why they would not apply DSM-III's complete criteria, for example, is quite clear if one considered the following facts:

1. As mentioned in the previous chapter, psychiatry is a recent profession in Kuwait, thus there are very few psychiatrist who have had to deal with a large number of cases. A proper application of a long list of criteria and complicated definition, as in the DSM-III, for example, needs no less than 20 minutes for each case. Every doctor has to interview (40) patients in the out-patient clinic, which means 800 minutes must be provided for sufficient diagnosis for all cases. If the doctor is not familiar with DSM-III, more than 20 minutes would certainly be needed. (The same problem can be seen in Botswana and in many developing countries - see Ben-Tovim, 1985).

2. Because of the shame and stigma attached to the labelled individual, the schizophrenic, for example, may remain undiscovered for many years. This situation will create many difficulties for the psychiatrist in deciding whether the case has 'schizophrenic' disorder (a duration of more than six months is needed to establish the diagnosis) or 'schizophreniform' (more than two weeks) or a typical or 'reactive psychosis' (less than two weeks). In other words, it is very difficult to specify accurately the chronicity of schizophrenia due to the fact that many patients show unstability in terms of the presented symptoms and the long term outcome (Kendell, 1983).

3. Almost all diagnostic schemes encourage mental health professionals to use their personal 'experience' in the clinical judgment. The fact that DSM-III, for example, is based on a descriptive (a theoretical) analysis with a significant lack of empirical research

and strong evidence or operational definitions of many psychiatric disorders, had led many psychiatrists to rely heavily on their subjective, personal experience and their cultural norms of interpretations. Suppose, for example, that a Kuwaiti patient complains of headache. Then suppose he goes on to say that his headache is caused by an "evil eye". If this patient is well educated, the British psychiatrist, for example, will find that specific explanation bizarre due to the inability of the patient to give an explanation of his headache that sounds reasonable in terms of the psychiatrist's own experience. That is to say, the British psychiatrist would probably use his concept of an acceptable standard of 'physical explanation' that is used by all 'normal' people in Britain as criteria of judging the abnormality of our case. As a result, the British psychiatrist will start to view the patient as "a paranoid psychotic". A Kuwaiti psychiatrist, on the other hand, is likely to appreciate that the patient's belief is culturally normal and may as a result consider a number of different possibilities, e.g.

(1) the patient's headache may have certain organic causes and the 'evil eye' is irrelevant;

(2) relating physical complaints to some 'evil eye' is considered to be an acceptable explanation for all Kuwaiti culture;

(3) the patient may have a family problem and the headache is an expression of these problems. (The above hypothetical case was originally adapted from Rack, 1982.)

In addition, if one examines, for example, current textbooks in developmental psychology published by Western authors, one would

notice that the main function of the 'normal' or 'mentally healthy' family is to provide the adolescent with enough emotional stability and security to enable him to separate himself from the family environment (Lidz, 1971).

However, it could be said that almost the reverse is true for Muslim societies where maintaining long-term continuing ties between the members of the family is considered to be the main goal of child-rearing. In Kuwait, for example, a person who separates from his family would be considered as not a true Muslim and the family that encourages such separation would be viewed as abnormal and needing counselling.

The above example shows clearly how the Western concept of mental health or mental illness is imposed on non-Western cultures who have different forms of philosophy and life-experiences (Fernando, 1988). According to the Western concept of a mentally healthy family, a Muslim family might be viewed as abnormal because it is 'father-centered' or 'authoritarian' or 'too close'. Although such characteristics are considered to be positive in the Muslim family, Western psychiatrists might consider such a family as pathological or not totally healthy because it departs from what had been accepted as the 'healthy' norm for the white nuclear family (Ibid., 1988).

Thus, as previously mentioned, the problem of many psychiatric diagnostic systems is that they do not take into account the role of such subjective impressions or current norms in different cultures

or the definition of the problems at a personal level. Let us elaborate what we mean by personal levels in some detail. In Kuwait, for example, most psychiatric patients cannot accept a definition of their problem in terms of unconscious inner conflicts or in psychoanalytical language in general. European patients, for example, tend to perceive their problems in terms of duality, e.g. "body or mind", "organic or functional", "genetic or environmental", whereas in most Third World countries, they are likely to conceive their sufferings in terms of a "continuum" without specifying accurate or systematic boundaries (Wig, 1983).

In addition, because psychiatric service in Kuwait is a new profession, many psychiatrists over-evaluate current Western psychiatric definition schemes. Such emphasis on using criteria alone creates two problems: 1) It gives psychiatrists in Kuwait an immature conception of certainty in the definition of mental illness and 2) it maintains and reinforces public confidence in psychiatric decisions based on an objective and scientific basis. Despite this, many mental health professionals are fully aware that the limitations of their psychiatric tools might bring about a negative attitude towards their professions. It must be emphasised in this respect that many mental health professionals in Kuwiat, as everywhere else, are vulnerable to the certain negative aspects of their profession, particularly after working for many years in a mental hospital. Thus, mental health professionals are often overwhelmed by feelings of helplessness and anxiety (burn-out phenomena) (Farber, 1983; Freudenberger, 1980) because they recognize that:

(1) Their diagnostic tools do not always provide them with a valid estimation of the individual's mental problems.

(2) Their prediction of dangerousness and later functioning is not always reliable.

(3) Their therapeutic skills are not fully effective.

(4) Many patients suffer from different courses of relapse in their post-hospitalisation period.

(5) There is no world-wide accepted definition or medical theory or model that is approved by all mental health professionals.

As a result, psychiatrists develop an unconsciously aggressive attitude towards themselves for selecting such specialities or towards their patient who continues to give them the feeling of failure and eventually feelings of powerlessness and feelings of guilt.

For that reason, many mental health professionals try to change their career from a clinical to an academic setting or to develop their sense of accomplishment (which they lack generally) through publishing books, writing articles, and generally trying to educate the public through the mass media. That is to say, their main preoccupation may shift gradually from the clinical setting where the identification of success is very difficult to a non-clinical area where one's commitments and obligations are of a different nature and the compensation is very high. However, for the psychiatrist who does not succeed in changing his career there is always the danger that he will gradually become less sensitive to the patient's needs or his rights. For example, such a psychiatrist might start to ignore the importance of seeing the patient regularly or the necessity to

apply a follow-up treatment plan. That is because the psychiatrist believes that, at the end of the day, the inevitable result will be a deterioration in the patient's condition rather than a cure. The above argument could possibly explain some of the dynamics behind psychiatric abuse. That kind of practice marked by uncertainty had led many mental health professionals to ignore the importnace of the content, meaning and purpose of psychiatric symptoms, the role of observation in determining the validity of such symptoms, and the involvement or the role of non-psychiatric factors in their decisions (see, Cocozza and Steadman, 1978).

As a result, one must be very cautious when examining the psychiatric clinical rationale implied in diagnosis or research objectives. Many psychologists and psychiatrists, for example, try to provide a neuropsychological explanation for the concept of mental illness. Venables in Frith and Done (1988) proposed a 'defective filter' theory in which the 'schizophrenics' are believed to have lost their brain capacities to filter out the irrelevant information. In a related attempt, Frith and Done (1988) present what they called an 'internal' or 'central monitor system' in which the schizophrenic suffers from a confusion in distinguishing between 'spontaneous or self-generated actions' and environmental stimuli. Frith and Done believed that the mechanism underlying the delusions and hallucinations that occur in the schizophrenic are due to the disturbance in the patient's monitoring system which eventually leads to a confusion about the source of actions or thoughts. For them, such a confusion might be the result of brain defects. The question which needs to

be addressed here is how one is able to identify the limits and boundaries of such inner psychological apparatus. What is presented above is merely a hypothetical inner abstract without giving any account of how an individual becomes a mental patient or the significance of his subjective experience or the effect of non-clinical factors in perpetuating his disturbance (see Scheff, 1975; Leiffer, 1969; Szasz, 1979, 1984, 1987; Laing, 1960; Laing and Esterson, 1970).

That is because the general purpose of any definitional or research attempt is to classify subjects according to what they commonly share with each other or their family grouping, which means that the individual's differences and uniqueness are disregarded (see Valentine, 1982; Ingleby, 1981).

It could be argued, therefore, that the diagnosis of mental illness within the general framework of DSM-III, for example, often emphasises arbitrary and unimportant traits or qualities, while omitting central unique differences among individuals. Labels such as 'being out of touch with reality' or 'loss of insight' (see the three definitions quoted earlier in this chapter) or 'defective filtering' or 'monitoring', as suggested in the above studies, ignore or do not give a sufficient insight into how the individual patient uses his mental awareness or his personal motivation in fitting himself to the environment. Furthermore, such terms ignore the extent, nature and the manner in which the labelled individual deals with reality or with his loss of insight or how he perceives his reality or the relative nature of such reality.

Moreover, the use of definitive terms such as "mood disturbance", "delusion", "disorder of thoughts", etc., in the diagnostic criteria, may create a wrong conception of discontinuity between normal and abnormal behaviour (Nathan, 1980). Rimland (1961) has summarised this position by arguing that some patients in mental hospitals are "saner" than non-patients, and that it is sometimes difficult to draw a clear line between "deep unhappiness" and "psychotic depression" or between anxious and depressive symptoms or between schizophrenic episodes and reaction to drug abuse (see the study presented at the APA annual meeting by Wilkins cited in Psychiatric News, June 17, 1988). Another example is when the psychiatrist has to deal with patients that can be defined as either schizophrenic or suffering from endogenous depression, when in reality he might be designated as suffering from both illnesses, or neither, or he may be suffering from some sort of illness which the psychiatric definitional system is not yet prepared to identify (Drury, 1973). The term schizophrenia, for example, when used by psychiatrists, usually implies the presence of symptoms such as bizarreness of thought or irrationality rather than specific physiological deviation (as some organic psychiatrists claim in their definitions). It is not difficult for the reader of abnormal or clinical psychology to discover the lack of an agreed and well-defined theory on the real causes of schizophrenia. The psychiatrists themselves are well aware that they are controlling the patient's thoughts for the sake of his family and society, rather than curing certain biological abnormalities.

For that reason, many psychiatrists in Kuwait avoid telling the patient his diagnosis either because they know very well that terms such as 'schizophrenia' do not tell us much or because they have doubts about the accuracy of the diagnosis or because they are afraid that they might be wrong. Moreover, the patient may be inclined to doubt the validity of a diagnosis of schizophrenia or may fear the onset of many attacks and relapses (which do occur in many cases). In other words, terms such as 'schizophrenia' tend to motivate the public to think in terms of 'irreversibility' or 'progressive deterioration' or 'chronicity' (Drury, 1975). This has led Drury to emphasise that words such as 'hysteria', 'character neurosis' and many psychiatric words can create an inaccurate frame of understanding. According to Drury, many psychological theories that are widely accepted throughout the world have become 'fact-proof' due to their being based on "logical error" rather than on clear conceptual and scientific foundation.

Drury goes on to cite Wolp's learning theory of neurotic symptoms. For Wolp, the stimulus for floating anxiety is 'space', 'time', and the 'idea of self'. Using such terms makes it difficult, if not impossible, to test them experimentally. Therefore, in Drury's own words, "... it is not possible to refute him [Wolp] because he has said nothing" (Drury, 1973, p.17).

Drury's criticism of Wolp's ambiguous terms highlights the importance of the vocabulary mental health professionals use in their daily practice. The importance of psychiatric terms results

from the following three facts:

1. Such terms shape the way mental health professionals think and behave.
2. It is not only the labels or terms in themselves which create the problem but also the moral consequences of such terms which might be permanently fixed.
3. Many psychiatric terms might create a confusion in understanding where the psychiatrist who uses such terms might indicate a specific professional meaning and the patient might formulate a very different kind of understanding. e.g. hysteria = not to be taken seriously; alcoholic = loss of control; schizophrenia = mad, etc. (For more details, see Drury, 1973).

A full acount of the above three points will be discussed in the last section of this chapter.

The previous discussion of the problematic nature of psychiatric definition inevitably leads us to question the clinical reality of conditions described as mental disturbance. In the following pages, we will examine the concept of mental illness when applied in a clinical or research setting or in actual practice and we will show how such a concept poses different theoretical and practical questions which need to be resolved.

The Concept of Mental Illness: The Clinical Boundaries and Limitations

> "If sanity and insanity exist, how shall we know them?" (Rosenhan, 1976, p.28)

In general terms, there is a great deal of controversial data on the reliability, validity, and meaning of such terms as are used to define the concept of mental illness (Webster, 1985; Martin, 1985; McGuire, 1973; Rosenhan, 1973; Kendler, 1987; Fabrega, 1987; Schacht, 1985; Gorenstein, 1984; Beck in Davison and Neale, 1986; Ennis and Litwack in Helzar, 1977; Ward et al in Helzar, 1977; Fuhrer, 1986; Ben-Tovim, 1985; Simon and Zusman, 1983; Mezzich et al, 1985).

As noted earlier, the lack of necessary and sufficient conditions for an accurate applicability of psychiatric definitional terms and the presence of overlapping and inconsistent criteria for the description of mental phenomena, have contributed to the low degree of validity in the definition of mental illness (Macklin, 1981; Costello, 1970). For that reason, some groups of mental health professionals have pointed to the need for a careful and detailed system of definition and classification of mental illness (e.g. DSM-IV and ICD-10 are in the process of research and development in the hope that such new editions of the above systems would solve the current problem in psychiatric definition and classification of mental illness).

Another group of mental health professionals and researchers represented by Szasz, Laing, Leiffer, Scheff, etc., argue as previously mentioned, for a radical change in the current system of definition of psychiatric disorders and the need to free the definition of mental phenomena from concepts such as disease, health, and other medical terms.

The above controversy which centres around the validity of the concept of mental illness does not mean that abnormality, or mental suffering do not exist. Nor does it imply that psychiatric labels are totally devoid of objective significance, are wholly lacking in diagnostic criteria, or are totally discontinuous with labels concerning physical illness. Such labels and feelings do exist in reality, but the 'clinical' diagnoses or labels which follow from such conditions as "schizophrenia", or "manic-depressive psychoses" or different forms of mental illness in general may be "less substantive than many believe them to be" (Rosenhan , 1976, p.28).

Now, if we believe that mental suffering or anxiety represent real clinical symptoms in the medical sense, can we accept the psychiatric interpretation of such symptoms? In other words, would the presence of such symptoms within the general framework of psychiatry as a medical profession justify the interpretation of such symptoms as residing inside the patient, or can such symptoms be related to the environment? Again, if we consider the DSM-III definition of mental illness, for example, it reflects the assumption that the individual's total life and experience is irrelevant or can be easily

separated and controlled when conducting a mental state examination. In recent years, the above assumption has been debated on the ground that mental health professionals are more likely to develop a false estimate of the extent of their actual knowledge and awareness of environmental and psychological factors (Mechanic, 1985). What is more, such factors tend in many cases to be misleading and confusing when considered in the context of a single disturbed experience rather than within the totality of the individual's experience and functioning.

The above mentioned clinical limitations of the concept of mental illness are well illustrated in a controversial study by Rosenhan (1976) in which eight normal people succeeded in admitting themselves to twelve mental hospitals by claiming that they suffered from certain hallucinations and anxiety. All of them except one received the definition of schizophrenia and although they then started to behave normally, it was fifty-two days before the last one gained release. "Patient engages in writing behaviour" was one of the nursing notes discovered on one of the pseudo-patients who was never asked about his writing. Clearly, the hidden assumption was that since the patient is in a mental hospital, therefore, he must be mentally unhealthy. Consequently, "writing behaviour" must be an evidence of such mental disturbance. Thomas Szasz (1983) illustrated this point by stating:

> "In psychiatry the classificatory act functions as a definition of social reality. As a result, no one committed to a mental hospital can be "normal" because his very commitment defines him as "mentally ill"." (p.212)

In reality, even if the patient is discharged from the hospital after being 'cured', he will still be considered by 'others' as potentially 'sick' and every single instance of behaviour which doesn't fit the general expectation would be considered as a sign of potential breakdown and a real threat to the acceptable norms of 'healthy' personality.

Now, Rosenhan believed that the fact that his pseudo-patients were diagnosed as mentally ill, even though they did not display a group of interrelated symptoms is a prima facie evidence that normal individuals or people with an average 'problem of living' can be differentiated from the seriously abnormal one. But, according to Rosenhan (1976):

> "When the sanity of the pseudo-patient was never discovered, serious implications and challenges should be raised to those who support the traditional modes of psychiatric diagnosis." (p.251)

Thus, Rosenhan's study shows clearly that it is very difficult to conceptualise a clear dividing line or a neat boundary between normal and abnormal behaviour. In other words, the grouping of mentally healthy individuals at one end of the spectrum and mentally ill people at the other end is difficult to accept.

Another study which demonstrates the unreliability of psychiatric diagnosis is that of Aaron T. Beck and his colleagues in Davison and Neale (1974). Beck and three other well-qualified psychiatrists diagnosed 153 pat ients during their admissions to the psychiatric hospital. The psychiatrists used DSM-III in their

diagnostic procedures. Although the psychiatrists had met to discuss the DSM-III criteria before interviewing the patients, they reached two different diagnoses. The reason for disagreement between them, according to the study, was due to the lack of clarity in certain criteria in the manual. The differentiation between criteria which was needed was too fine, and the presence of these particular criteria was not specific enough. As a result, the diagnostician would be obliged to use non-specific or general criteria rather than specific one. That is to say, the clinician would be more in favour of using, for example, the criteria for "schizophrenia" rather than for "Hebephrenic or latent type".

Lipkowitz and Idupugant in Cohen and Cohen (1986) have shown in a related study that there are significant disagreements between mental health professionals over the interpretation of many psychiatric terms such as 'schizophrenia'.

A case study by Simon and Zusman (1983) concluded that a psychiatrist who was hired by the respondent's side in the courts will reach a different conclusion than the plaintiffs one. In both groups of psychiatrists, their questions were formulated in such a way as to gather certain expected information that is most appropriate to satisfy the policy of the institution rather than the benefit of the patient himself. For example, the plaintiffs' psychiatrists were more prone to see disease, while the defendents' psychiatrists tended to oppose any affirmations about the presence of disease in the person (contextual effects).

Another study by Fuhrer (1986) on 136 French psychiatrists led the researcher to conclude that they were using their experience more than the DSM-III in respect of certain Axes.

Finally, Ben-Tovim (1985) has conducted a research study on the applicability of DSM-III in Botswana. Ben-Tovim discovered that citizens in Botswana do not really believe that long-term problems are serious or display a need for psychiatric intervention. Therefore it is difficult to apply Axis II (personality disorder and specific developmental disorders) in this country. The researcher emphasised the fact that some psychiatric conditions are culturally specific, for example, Axis IV (which assumes a long-term marital separation as an indication of severe stress). In Botswana, marital separation is not viewed as causing severe or even mild stress due to the poor quality of grazing land in this country which requires most people to take their cattle to be grazed elsewhere. Additionally, in Axis V child and adolescent adaptive functioning is significantly related to school performance, whereas in Botswana, Ben-Tovim maintained, education is not compulsory and it is very normal for children to be absent from school for a long time or even not to attend at all.

The studies discussed above indicate the difficulties in specifying a clear and workable system for the classification and understanding of the concept of mental illness. It must be re-emphasised that the crucial factor which is responsible for such conceptual limitations of the concept of mental illness is that many mental health professionals refuse to allow socio-cultural factors to enter

in their diagnosis of conditions described as mental illness. That is because they view such factors or values either as unspecific and too diverse, and thus incapable of being put under scientific control or prediction, or as "... a state of affairs existing somewhere beneath a person's skin" (Rimm and Somerville, 1977, p.36).

Leiffer (1969) describes the above problem stating that "To claim that mental illness has a meaning independent of psychiatric social functions and values is analogous to claiming that money has a meaning outside of the economic system in which it is used" (p.111). That is to say, the concept of mental illness is not a "neutral, value free, concept" (Scheff, 1970).

One cannot deny the fact that "varying customs and accepted behaviour in different cultures necessarily precludes a universally applicable conception of mental illness" (Macklin, 1981, p.399 and see also Feinstein in Anthony Clare, 1980). The absence of a comprehensive psychopathological view of human behaviour that is acceptable to most mental health professionals in the field, creates many theoretical and practical obstacles in providing a universal applicable criterion for the definition of mental illness (Macklin, 1981). Even in the same culture, however, the concept of illness fluctuates from time to time. Consider the problem of "homosexuality". Before 1974, homosexuality was defined as sexual dysfunction and represented a central criterion under psychosexual disorders in the DSM-III. However, the American Psychiatric Association (APA), under continuous pressure from different liberation groups (such as Gay Movement), voted in

1974 to drop homosexuality from the classification of mental disorders. In fact, a careful anthropological study of different societies would reveal many differences in the definitions of what constitutes psychiatric conditions and in the interpretations of those conditions (see a study by Baskin, 1984). Thus, it is very difficult to conceive of any possibility of applying the DSM-III view of appropriate standards of mental health and illness to all cultures because this system of diagnosis is largely established on American values, culture and private philosophy which are by no means universal.

Consider, for example, the two fundamental American values of self-reliance and personal strength, which have created unsympathetic attitudes towards individuals who are 'weak' and not 'self-reliant' (Townsend, 1978). If, on the other hand, we consider an Islamic context, it would see that Muslims are more in favour of adopting a code of ethics or conduct which is centered on the notion of responsibility towards others. God is the ultimate power, therefore Islam accepts weakness, helplessness, or disease. What is more, Islam emphasises the importance of the responsibility of every individual for the well-being of society and the obligation of every member of society for the welfare of others, which should equal his obligation to himself. Another cultural value in Islam is that the 'true' Muslim must be completely dependent upon God, in whom he believes, as his guide, director and supporter. According to the Quran:

> "Say: Nothing will befall us other than that which Allah [God] has decreed for us. He is our patron; and in Allah let believers rely and put their trust." (II, 59: V.51)

Thus, God-reliance rather than self-reliance is the basic value in Muslim countries. Now, when examining the value of being 'strong', important concepts in Islam need to be analysed. In Islam, being disadvantaged or poor or needy is an honourable state which receives a significant value among Muslims.

That is because the more patience or tolerance the individual shows towards his weakness, the more he gains a higher rank among believers in the hereafter. In fact, the sick or the weak are considered by Muslims to be close to 'God'. "If a man has only his Islam and his health, it is sufficient for him" (The Holy Prophet). According to the Quran:

> "Your wealth and your children are only a trial.
> Whereas Allah with him is an immense reward."
> (6, S 64: V.15)

Thus, in Muslim countries, the best man is not the strong one, but the one who is useful to mankind or who loves his brother (other Muslims) as he loves himself and the one who can tolerate his weakness or disease without complaint. What would be expected as a result is that a long-term impairment and a chronic feeling of weakness or helplessness would not be taken as evidence of mental illness in any Muslim society.

Although the culture-specific nature of the concept of mental illness and its conceptual limitations has been established, that does not prevent many mental health professionals from holding the belief that there are predetermined genetic factors underlying

the problem which will be discovered in due time. (For more details on the arguments for and against medical and genetic determinism, see Bloch and Reddaway, 1984; Szasz, 1987; Schacht, 1985; Millon, 1983; Persons, 1986; Coleman 1967; Kety, 1971; Sarbin, 1967.) Such a belief, as mentioned earlier, motivates some mental health professionals to regard mental illness as permanent with constant deterioration regardless of later behaviour and social functioning (Coleman, 1967; Tarrier, 1979). Thus, many psychiatrists are conditioned to believe that mental illness refers to a long-lasting defect in the 'patient's' personality and has a poor prognosis. Moreover, when the psychiatrist designates a person as mentally ill, such definition does not imply that the patient's thoughts or behaviour or beliefs are irrational, but that the individual himself as a whole is irrational (Moore, 1982). Even if the 'patient' manifests episodic reasonable behaviour from time to time, the clinician's response "... may be overdetermined by the detail, without due regard to other features now occurring with in. The response is thus determined by past contexts rather than by present contexts. It is therefore likely to be bizarre, inutile, maladjusted, and hence neurotic ..." (Hollingworth in Ullman and Krasner in Millon (ed.), 1973, p.300). Moreover, when judging the individual behaviour as bizarre, irrational, or 'delusional', such terms are not merely a 'description' of his behaviour as the DSM-III claims, but in reality imply a 'prescription' of how to deal with the labelled individual (Szasz, 1987; Clare, 1976; Rem, 1982; Leiffer, 1969).

Thus, by stating that the person is not mentally healthy or 'abnormal' the clinicians place themselves in a situation where they have to take some sort of action usually by means either of technical intervention procedures such as the use of psychiatric medication throughout the application of involuntary commitment as in the case of Mr. Duzynski or of 'non-technical interventions' such as counselling or psychotherapy (usually by means of voluntary procedures). Ironically, the voluntary patient will soon discover that it is difficult for him to gain discharge from any therapeutic procedures without the prior approval of the psychiatrist in charge. Such shifting from a voluntary to non-voluntary position is a common practice for many psychiatric patients, especially in the Third World countries.

It seems to the present writer, however, that the problem of the evaluative component of the definition of presented symptoms largely stems from the fact that what mental health professionals actually define is the form rather than the content of the symptoms. Mr. D's spending behaviour was viewed as representing a radical departure from the socially acceptable norms of charity. A careful analysis of Mr. D's spending behaviour within the context of his total life and psycho-social functioning would surely change the definition of his rationality.

The question which needs to be addressed here is why psychiatrists generally give little concern to the importance of the patient's subjective meaning and the content of their disturbance. C.G.Jung (1960), in his book "The Psychogenesis of Mental Disease"

answered the above question by stating that:

> "the medical student, being overburdened with specialised studies, cannot allow himself to make digressions into the realm of philosophy, and is subjected exclusively to the influence of materialistic axioms. As a consequence, researchers in psychiatry are concerned mainly with anatomical problems, so far as they are not pre-occupied with questions of diagnosis and classification. Thus the psychiatrist generally considers the physical aetiology to be of primary importance and the psychological aetiology to be only secondary and subsidiary; and because of this attitude he keeps in view only causal connections of a physical kind and overlooks their psychological determination ..... Physicians have often assured me that it was impossible to discover in their patients any trace of psychological conflicts or of psychogenic symptoms, but just as often I found they had carefully noted all the incidents of a physical kind and had failed to note all those of a psychological kind ... because of a typical undervaluation of the importance of the psychological factor." (p.212)

It is true, as Jung argued, that medical students put great emphasis on the biological basis of behaviour rather than its psychosocial origin. In actual practice, however, the problem occurs when the resident psychiatrists try to deal with people classified as 'mentally ill' by relying on their medical training. The problem with general medical training is that it was originally established for solving defects in the body rather than defects in behaviour.

The above limitations have led many resident psychiatrics to "become obsessively pre-occupied with conventional medical details as a reaction to the vagueness and uncertainty of psychiatric principles" (Halleck and Woods in Light, D., 1980, p.247).

A further consequence of the uncertainty of general principles and definitions in psychiatry is that diagnostic or definitional terms are used in an uncommitted way. Most psychiatrists and residents do not take the DSM-III terms, for example, very seriously due to the lack of content and meaning of many psychiatric terms. This has motivated many psychiatrists to compensate for the defects in their definitional terms, by using their personal inclinations rather than the DSM-III information to make a diagnosis. Furthermore, they endorse techniques (treatment) without giving a great deal of thought to the impact of such therapeutic procedures on the patient's problem. In fact, the general medical training of psychiatrists has made them minimally sensitive to the fact that mental illness can only be comprehensible and intelligible when the individual's psycho-social identity is taken into account (Rack, 1982).

The central problem with general medical training is that it shapes the psychiatrist's methods when dealing with individuals suffering from certain 'problems of living' (Szasz's term). As a result, the psychiatrist's questions are phrased in a manner that assumes a pathology in the person rather than something which might be the result of external environmental pressures. An example of the promotive questions that are cited in Light (1982) are: "Do you have any trouble with your mother?" (This question can give the individual the right to deny or to agree on the information implied in this question.) The above question, although it suggests context, rather than inner pathology, can be framed in a way that can assume any response from the patient, so that even a denial would be an

indication of pathology or a sign of symptoms. The question becomes: "Tell me about your trouble with your mother?" (Ibid., p.40).

Sooner or later, psychiatrists or residents have to come to terms with the fact that their discipline is largely governed by conflicting models of interpretations and unspecified aetiology of mental illness. Being mentally ill, for many psychiatrists, is a very serious fate and the notion of a cure is no more than a myth. As a result, many mental health professionals are accustomed to applying diagnostic labels without giving them much concern. Moreover, they have to face in their practice 'healthy looking' patients who are presumably sick and their diagnostic system must help them in detecting the abnormality of such cases (Light, 1982). Because of this, many psychiatrists tend to rely mainly on the episodic phases of psychosis for example, or on third party claims (as previously mentioned), rather than on the actual behaviour of the 'patient's' total functional performance to prove pathology underlying the presence of abnormality (Meyerson and Hamilton, 1985). For that reason, DSM-III puts great emphasis on the "shared descriptive clinical features" between people rather than on the understanding of the cause of mental disorders (Spitzer, 1985). Thus, whenever the aetiology factors or the content of mental illness is "... weak, the diagnostic descriptions or criteria become culture-specific" (Wig, 1983, p.83) and more socially determined. That led psychiatrists to justify their medical status by assuming that at the "bottom all mental illness has an organic basis and can be treated most effectively by physical means" (Caine & Smail, 1969, p.12).

This, however, is not to say that psychiatry, as many writers such as Scheff (1966 and 1975), Laing (1960 and 1983), Gove (1982), Szasz (1987), Fernando (1988) claim, is completely governed by uncertainty and moral values or cultural factors. In actual practice mental health professionals have to use in their daily practice workable categories and practical psychological tests to identify many psychological symptoms such as 'withdrawal', 'delusion , 'hallucination', and so on. However, because such symptoms, as mentioned previously, differ in the way they manifest themselves in each society and since they may occur in perfectly normal people, employing a strict moral criteria in the diagnosis of human problems obscure rather than facilitate any effective psychiatric remedial intervention. Nevertheless, there are certain clear-cut forms of mental illness which cannot be interpreted on the basis of moral and cultural criteria exclusively. What mental health professionals need, however, is a balance or a compromise between the necessity of promoting the patient's moral status or values and the need for a workable psychiatric classification. Such balance between moral values and workable psychiatric classification will be discussed in detail in following chapters.

Pushing the argument further on, let us first of all highlight the relationship between the psychiatric definition system on the one hand and the patient's moral agency on the other hand.

The definitional limitations and the moral agency of the labelled individual:

> "In medicine it is possible to act as if there were no right or wrong streptococci, merely dangerous ones. In psychiatry there is a formal effort to act as if the issue is treatment, not moral judgement, but this is not consistently maintained. Ethical neutrality is indeed difficult to sustain in psychiatry, because the patient's disorder is intrinsically related to his acting in a way that causes offence to witnesses." (Goffman, 1961, p.318)

Although ethical neutrality is difficult to maintain in the psychiatric definition of mental disorders, most psychiatrist will

> "... dispute that their ideas on mental illness have any moral significance ... It is common for psychiatrists to regard their work as a kind of technology, which is seen as a means for producing a certain result (viz. mental health) which can be objectively defined. And it is often argued that just because the goal of therapy is 'objectively definable', the only relevant criterion for evaluating the success of therapy is in terms of its efficiency in achieving this 'objectively defined' goal, and therefore that moral considerations do not play any part. According to this view then ... a judgement of illness is not a value-judgement, but an objective and factual one; and psychiatric theory is a scientific theory which neither raises nor answers any moral questions." (Sayers, 1973, p.2)

Moreover, just because it is difficult to avoid a moral view of the individual problem, that does not mean that the diagnosis is itself inherently a moral judgement. Nevertheless, the diagnosis may still have morally sensitive possibilities. If, for example, the individual is diagnosed by the psychiatrist as having some sort of personality or psychosexual disorder, the form of treatment as a result would

be 'counselling' or 'rational-emotive therapy' or some other kind of 'psychotherapy'. If, however, the 'patient' is believed to have certain psychotic or affective disorder, the psychiatric intervention would take a totally different shape. The main 'therapeutic' procedures with the psychotic would imply 'ECT', 'anti-psychotic medication' and major tranquillizers with a long-lasting side-effect (see Torrey, 1974). The question which arises from this argument is why the therapeutic intervention is different in both cases.

It seems that psychiatrists have two concepts of management when dealing with neurotics and psychotics. Being 'neurotic' would lead to the assumption that the 'patient' is valid, is capable of rational choice, is aware of others, is educated, has an insight and is a full human being. The neurotic patient, for psychiatrists, belongs to a group of well-educated people who need a careful interview, good counselling and high respect because they are capable of understanding. The psychotic, however, in the mind of many mental health professionals is highly associated with dangerousness, agitation, unpredictability, excitement, withdrawal, bizarre thoughts and behaviour with a complete lack of insight (out of touch with reality) (see Torrey, 1974). Thus, such bizarre thoughts and severe symptoms need a severe and bizarre treatment to 'restore' the patient's autonomy. In fact, many psychiatrists ignore the episodic nature of psychotic symptoms and the capability of the psychotic patient to be prima facie capable of rational choices (Wear, 1980).

However, writers such as Jung (1960) believe that the ability of mental patients to function adequately is an indication of "... early signs of a defensive nature. This is a symptom of weakness, not of strength" (p.244). Thus, for such writers, even positive 'normal' behaviour is interpreted as a sign of 'mental weakness'.

Such pessimistic attitudes have led many mental health professionals to be sensitive and alert to their reactions towards the labelled individuals. Therefore, it is not surprising to find that a central part of the training programme for new mental health professionals in many mental hospitals, in terms of effective relations with 'psychotics', implies the following instructions:

> "Don't get caught in collusionally false sentimentality. If you give them an inch they'll take a mile. Keep your distance. Keep them in their place. Don't lose yourself in 'over-identifying' with them. Don't inflame the psychotic process by rewarding psychotic symptomatology."
> (R.D.Laing, 1985, p.28)

The above quotation from Laing shows clearly that being 'mentally ill' can create a set of negative attitudes which can maintain and strengthen the general beliefs that occupying the role of mental patient - that is that he represents a radical deviation from socially acceptable definitions of competency and moral agency to something that can be best characterized as not fully human.

Now, if the basic attitudes among mental health professionals are essentially grounded on the assumption that mental illness equals losing one's moral and rational agency and free will, then the treatment prescribed must also obviously be tailored to fit such assumption.

Consider, for example, the application of behaviour therapy procedures to both 'psychotic' and 'neurotic' individuals. The behavioural model works on the belief that 'patients' can easily be manipulated and their behaviour can be remodelled according to the stimulus-response methods without any concern to the free-will, self-determination, and personal responsibility of such 'patients'.

For behaviourists, the reality of mental symptoms must be understood as the result of a mechanistic correlation between traumatic stimulus and faulty conditioned response (C.Rs). A young girl who saw her mother die while crossing the street one evening, would develop a conditioned depressive reaction towards a specific time of the day (i.e. the evening) because sunset correlates with her mother's death. The treatment procedures would be controlling "... the symptom itself, i.e. by extinguishing unadaptive C.Rs and establishing desirable C.Rs" (Eysenck, 1973, p.343). One could then imagine that the treatment of the young girl would employ certain recreational activities at sunset or the control of the anxiety impulse through desensitization methods or any other behavioural method, such as aversion or modelling, etc. Surely, the above approach is too simplistic and the way our problem develops and the methods we employ to deal with our troubles are too complicated for any

single correlation method to explain (for more details on the behavioural methods, see Wolpe and Rachman, 1974; Dollard and Hiller, 1973). (See Chapter Three.) Although it cannot be denied that such behavioural methods may have a therapeutic effect on the patient's total function, it is doubtful whether such behavioural principles could operate effectively if the patient did not confront and experience the expectations or the demands of such techniques by employing his free will, or was not advised and governed by his total reasoning and intention in activating his autonomous purposeful decision to stop the 'bad habit' or the 'pathological behaviour' (Ledermann, 1982).

In the 'token economy' therapy with the 'chronic' psychotic patient, the procedure is 'working successfully' not because of the superiority of such techniques, but for other hidden factors. A central unnoticeable factor is the 'psychotic' motivation to change. The 'psychotic' will surely behave 'positively' as the psychologists want (e.g. washing alone - eating by himself - decrease the aggressive behaviour, etc.), but that does not necessarily indicate an effective therapeutic agent implicit in such procedures (i.e. postive-negative reinforcement). That is because when 'tokens' represent for the patients the only method to satisfy basic needs in the wards (cigarettes, sweets, drinks, etc.), "patients work for them" by behaving in a way the staff expect them to behave (Bloomfield, 1976, p.79). Psychotics might decide to stay calm in the hospital and perhaps they hope to remain in the hospital for a long time. Such decisions taken by 'patients' might possibly reflect a logical choice that

is implemented by manipulating their behaviour (Braginsky in Townsend, 1978). Laing (1983) described the above by stating that:

> "... behaviourist theory comes to determine all decisions taken on what is to be done to you and me who are inadvertently implicated by way of being stuck on as utterly redundant appendages." (p.29)

Laing (1983) goes on to argue that being scientific or objective does not have to lead psychiatrists to ignore or disregard the patients' motive and intentions or to treat others as 'things'. The 'scientific' or behavioural methods when applied to both 'psychotic' or 'neurotics' may not actually take into account that individual's system of values, his motives and his experience which are devoid of objective content. The patient's subjective experience and his personal motivation can never be duplicated, or reproduced or put under control by S-R methods as they occur in an objective experiment (see Laing, 1960, 1983).

Mr. D's case illustration which was presented by Drury in Clark and Winch (1970) and discussed earlier in this chapter, is an excellent example of how the understanding of the individual's system of values and his subjective experiences would facilitate any real attempts to define or classify the presented symptoms (a more detailed analysis of Mr. D's case will be presented in Chapter 3).

Now let us examine the relationship between the psychiatric terms and the moral agency of cases such as Mr. D and Mr. Duzynski. In both cases, the definition of mental illness invalidates their claim - "You are an invalid, and what you say is therefore invalid:

You are sick because your label says so ..." (Dr. Alexander Mitchell in Clare, 1976, p.62).

It could be argued, therefore, that once the psychiatrist labels a person as 'mentally ill', he (the person) becomes invalid, and in some way, not fully human. He is not valid because he is not healthy. He cannot deny the description of his total life and experience as mental illness because no matter how much rationality or partial functional effectiveness he exhibits, there is a somatic pathology underlying his problem and predispositional factors which undermine any 'pretended rationality' and make him vulnerable. Thus, the concept of mental illness when used in practice promotes the meaning that both Mr. D and Mr. Duzynski's behaviour for example is involuntary, irresponsible, and unaccountable, "but this none the less involves a technical schema, not a social one, and ideally ought to disqualify the patient for any participation in the service relation even while qualifying him as an object of service" (Goffman, 1961, p.317).

Invalidation of the individual 'patient' is done either by labelling him as 'mentally ill' or by 'physical restraint' (Berke, 1977; and Klerman, 1977). The problem basically arises when applying the 'sick' role, which is basically derived from the medical model to psychiatry. Such application had led many mental health professionals to hold the belief that being 'mentally ill' implies 'irresponsibility' for one's behaviour. Thus, the 'patient' needs a medical intervention to restore his responsibility. Moreover, the application of the

medical model or sick role in psychiatry had consequently led to consider terms such as "illogical thinking", "metaphorical speech", "magical thinking", etc., (Quick Reference to the Diagnostic Criteria from DSM-III (mini-D), pp.103-106) not as implying a possible sign of the presence of mental illness but somehow as mental illness in itself. That is to say, for most mental health professionals, the above terms do not in themselves represent a description of the individual's 'bizarre' behaviour which might indicate the presence or absence of mental illness. Instead, such terms are taken to stand for mental illness itself (Light, 1982). As Szasz (1987) puts it "mental symptoms do not point to a possible illness, they are (the same as) a mental illness" (p.97). As a result, the clinician would interpret the individual's 'symptoms' not as something that merely indicates to a possible irrationality, but as evidence that the individual himself is really irrational.

Consider, for example, the DSM-III's definition of "Anti-social Personality Disorder". Such a definition tends to view the sociopath or psychopath as displaying a group of symptoms such as expulsion from school for misbehaviour, lying, irresponsible parenting, unorganized sexual relations, low school grades, violations of rule at home or school and refuse to accept social norms, etc. (For more details see Quick Reference to the Diagnostic Criteria from DSM-III, American Psychiatric Association, 1980, pp.179-182).

The above symptoms may or may not be a result or a consequence of 'abnormality' of personality (Blackburn, 1988). Furthermore,

the above descriptions are not in themselves personality characteristics. Such symptoms are not always present at the time of psychiatric evaluation. As a result, it is the past history of 'sociopathics' behaviour that counts. The past history rather than the presence of a real symptom or 'hard evidence' of pathological deviation in the individual's personality, makes the above definition of Antisocial personality "little more than a moral judgment masquerading as a clinical diagnosis" (Ibid., 1988, p.511).

In addition, when the concept of mental illness is applied in 'clinical' settings, the resultant effects on the individual patient tend to be very negative. In practice, the concept of mental illness is generally a set of societal value standards (Scheff, 1975; Szasz, 1987). When such a concept is attached to any given individual, it would "mark his deviation from one or another of these standards [societal value standards], rather than describe and explain his conduct. It labels him as bad, it justifies his isolation from the group, it classifies him as in need of behavioural and thought reform, and it deprives his actions of social legitimacy" (Leiffer, 1969, p.114). If a Kuwaiti patient, for example, is diagnosed as 'homosexual', this label immediately sets him apart from the rest of 'normal' Kuwaiti society. The problem is that such terms use an evaluation, yet are paraded as value-neutral scientific explanation. Thus, the concept of mental illness when applied in psychiatric practice promotes the meaning that the 'patient' is unreliable as a human being and he will sooner or later "degrade from full existential and legal status as human agent and responsible person to someone no longer in

possession of his own definition of himself, unable to retain his own possessions, precluded from the exercise of his discretion as to whom he meets, what he does. His time is no longer his own, and the space he occupies is no longer of his own choosing" (Siegler, Osmonde and Mann, 1972, pp.102-103). In other words, he (the patient) is "out of touch with reality", thus he misinterprets the events around him. As a result, the patient cannot be taken seriously. Scheff (1975) reacts against the above morally negative image of the mental patient by arguing that schizophrenia, for example, is defined by psychiatrists on the basis of "withdrawal", "flatness of effect", "thought disorder", language aberrations, and hallucinations or delusions. For Scheff, such image will surely lead to a view of the schizophrenic as a "passive, inward-dwelling, remote person who lacks interpersonal and other competences that other members of the society see as necessary to maintain or improve one's status in society" (Ibid., p.17). Such an image of the mentally ill individual might lead the authorities in a given society to undermine or weaken the importance of "equitable dealing, the preservation of liberty, and beneficient treatment ..." (Brody, 1985, p.60).

Thus, Mr. D and Mr. Duzynski can be viewed as "justifiably persecuted scapegoats" (Szasz, 1973, p.239) because their psychiatrists perceive their behaviour as closely connected with a list of negative concepts, such as: unintelligibility, unpredictability, unfitness, incomeptency, unawareness, etc. (Szasz, 1972, 1973, 1984, 1987; Moore, 1982, 1984). Accordingly, preservation of liberty and equitable dealing will be considered as a secondary matter.

From everything said so far, it becomes clear that our concern is not really with the possibilities that psychiatric labels may have an objective content or that such labels might have in the future an accurate operational criteria of diagnosis. Rather, our main concern is with the moral and ethical consequences of such psychiatric labels. Thus, it seems morally and practically desirable to limit the act of labelling to the very extreme and clear cases only and these are very few in psychiatric daily practice.

Accordingly, a plausible proposal would be that instead of trying to find commonality of symptoms or cause or lesions, mental health professionals in all countries have a moral obligation to investigate the actual process of labelling a person as mentally ill, the moral outcome of such labelling, and the significance of the individual's total functioning as reflected in psychiatric interpretation.

In conclusion, what mental health professionals need is not more revised editions of psychiatric manuals, but a humanistic and responsible consideration of the implication, meaning, and the consequences of being labelled as mentally ill. That is because "the very naming can damage the patient whom we essay to help" (Karl Menninger in Macklin, 1981, p.394). Throughout this chapter, the discussion acknowledges the damaging results which follow from placing a person into the class of 'mental illness', whether this classification has been made on subjective grounds or on the basis of actual symptoms displayed by the 'patient'. Surely, the most damaging effects result

from the application of the concept of mental illness to people who are not radically ill. Ironically, it is a fact that a high proportion of mental hospitals' inmates, in most countries, receive a diagnosis of 'schizophrenia' (the most common diagnosis of mental illness). In other words, most individual who have been admitted to mental hospitals are likely to be classified as 'mentally ill' (schizophrenic) rather than suffering from some sort of temporary personality or anxiety disorder.

A proposed definition of mental disorders

As mentioned earlier, the current definitions of mental disorders have received a considerable discussion among philosophers and mental health professionals in general. The definition of mental illness includes not only 'medically' objective terms but also socio-political decisions (see Scheff 1971, Goffman 1961, Szasz 1987). The gross abuse of psychiatry in many countries (e.g. Soviet Union) highlights the vulnerability and the limitations of the concept of mental illness in psychiatry.

Bearing in mind the subjective and evaluative nature of psychiatric diagnosis (see Cohen and Cohen, 1966), it seems difficult to be objective, not necessarily unsystematic, when defining mental illness. What hinders mental health professionals in establishing a consistent view towards mental illness is the complexity of psychiatric phenomena. A person who receives the diagnosis of 'schizophrenia', for example, might have an acceptable degree of insight, be able

to develop an adequate or moderate dealing with his everyday problems and prima facie, be self-governing. Another group of patients with a diagnosis of floating anxiety, on the other hand, might be uncontrollably tense and disoriented (Berke, 1977).

This has led us to emphasise the fact that being disturbed in one particular context does not necessarily mean that one should be labelled as 'mentally ill' and treated as such. One specific form of behaviour could be perceived by others as representing a major defect in reality testing. But it is doubtful whether such a single disturbed behaviour should be classified as a sign of 'illness' if the individual's total psycho-physio-social functioning shows little or no evidence of any significant radical deterioration from the acceptable healthy standards (Wear 1980 and Edwards 1983).

In the present writer's view, it may be useful to consider an account of mental illness which provides a morally rather than a conceptually advanced perspective of mental disorder by emphasizing the following aspects:

1. Mental illness is neither a necessary condition nor a consequence nor is it linked with physical or brain lesions.
2. The "mental patient" must be viewed as a unique person who has the right to evaluate his own suffering, and not as a type of 'disorder' with a mechanical cause.
3. Mental illness is basically related to the individual's total ability to function effectively in the psycho-physio-social aspects of his life.

4. Assessment for total failure in all the individual's major function is a necessary condition for deciding whether it is a case for treatment or not.
5. The individual's personal account of his functional failure is a sufficient condition for determining the degree of such failure.

These five aspects will be discussed and defended in the following chapters.

In conclusion, it might be more appropriate to consider mental disorder as a condition where an individual suffers from a temporary radical total functional failure in all his major psycho-physio-social functions. A temporary total failure might interfere profoundly with his problem-solving abilities and with his ability to cope effectively with the tasks of life.

The above definition which will be called a "Reactive functional disorder" (RFD, for short), does not necessarily mean that being in an RFD condition implies the presence of 'pathological manifestations' with underlying causes, or that an exact definition of a condition described as RFD will reliably reveal the causal chain of the disorder and the appropriate treatment to be used. Neither does it imply <u>prima facie</u> that the labelled individual lacks the will to be rational or that bizarre or illogical symptoms such as imaginary perception, or unjustified conceptions, or inappropriate emotional expression are recognised and identified by their causes rather than by the way in which they present themselves or the way they are experienced by the individual himself.

It must be emphasized here that the 'patient's' verbal report and his personal claim about his total functioning is more important than a third party claim in any psychiatric attempt to define the 'normality' of his functional effectiveness.

The reality as perceived by the 'patient' (Rogers, 1951) and the way the patient's perception might interfere with his insight is a crucial point to be considered in any psychiatric decision.

The above account attempts to incorporate some of the aspects of mental illness often omitted by current definitions, i.e. that psychatric disorder is basically related to functional disturbance as perceived by the 'patient' himself. It also tries to highlight the terminological limitations implied in accepted descriptions of mental illness and the negative consequences of such terminology on the 'patient's' moral agency. Terms such as "mental", in general, continue to motivate many mental health professionals to focus on inner unverified mental factors rather than external observable functions (Sarbin, 1967). Nevertheless, the term 'mental illness' remains a nebulous and fluid concept for it is intrinsically difficult, if not impossible, to draw clear and definite boundaries when dealing with human behaviour. This is because the reasons for such behaviour are inaccessible to direct physical examination. Consequently, the application of the medical or disease model which is highly preferred by many psychiatrists is misleading and confusing in many cases. 'Out of touch with reality' or 'disorder of thoughts' - terms which are considered to be highly scientific - fail to show whether the

patient has total or partial functional failure or to consider the moral agency of the labelled individual.

Therefore, symptomatic behaviour can be more adequately conceptualised in terms of specified functions as they are perceived by the patient himself rather than by relying on an ambiguous and unspecified symptom usually reported by significant 'others'.

Conclusions

A careful analysis of the current definitional system in psychiatry will lead to a conclusion that could be best viewed as disappointing (McGuire, 1973). That is to say that no exclusive definition of mental illness exists which is approved by all mental health professionals. Thus, while it is true to say that the DSM-III or ICD-9 provide a single definition of mental disorders, not all countries use these manuals in their practice of psychiatry (Cooper, 1988). Moreover, even in the same country (for example, Kuwait), some mental health professionals use in their diagnostic practice ICD-9 or DSM-III, while other professionals do not use any manuals or use both of the above mentioned manuals.

The above argument is basically related to the fact that to classify human problems is not an easy task that could be done in an objective way as many mental health professionals believe. The individual's concept of his suffering is something that cannot be understood by reference to certain laws of generalisation because

it is too diverse and much more limited to the individual's particular life experience. Moreover, it is very difficult, if not impossible, to detect and follow the individual's mental problem to its early stage or basic roots and cover sufficiently all aspects of the problem. That is to say that there is a problem of 'rarity' or conceptual clarity with which a particular psychiatric symptom can have a precise causal relationship to the presence of the symptoms (Kanfer and Saslow, 1973).

For that reason, most psychiatric classification schemes put a greater emphasis on the description or frame rather than the content of the disturbance.

In view of the almost complete lack of accurate aetiological perspective of most mental disorders, the inherent pejorative connotation and evaluative component of the concept of mental illness, and the ineffectiveness of most psychiatric treatment, one could put forward the following question:

What is the point or the value of psychiatric definition and classification of mental phenomena anyway?

We have suggested that the negative consequences of psychiatric definition are outweighed in many instances by the value of such a definition. A proper system of identification of the individual problem is the crucial requirement. For the purpose of classifying and identifying the people who need psychiatric help, we need a careful study of how to define and classify the individual

problem in a way that promotes the patient's feeling of respect and minimizes the morally negative outcomes of such definition.

In the present writer's view, a Reactive Functional Disorder Model is the best possible alternative. Such a model emphasises the importance of the individual's ability to recognise and define his need for psychiatric treatment. Moreover, such a model conceptualises a human problem as a total failure in the major psycho-physio-social functioning and not just as a partial failure. Mental health professionals, according to the RFD model, would be interested in specifying the kind of functions which are fully disturbed. Their job would be more effective if they adopted a view or a concept of autonomous "contractual" psychiatry which was developed originally by Szasz (1987). In 'contractual' psychiatry, the 'client' is totally free to enter either a therapeutic or diagnostic psychiatric relationship with the psychiatrist. A detailed account of the above points will be discussed in the following chapters.

CHAPTER THREE

THE REACTIVE FUNCTIONAL DISORDERS APPROACH (RFD) AND THE CONCEPT OF MENTAL ILLNESS

THE REACTIVE FUNCTIONAL DISORDERS APPROACH (RFD) AND THE CONCEPT OF MENTAL ILLNESS

Introduction

The current position of the concept of mental illness is the target of a deep psychiatric and philosophical discussion. Conflicting conceptual models of mental illness and the lack of reliable causal interpretation of psychiatric symptoms in current psychiatric manuals have both contributed to render the concept vulnerable to abuse.

The different conceptual models which are currently in use in psychiatric practice are as follows:

(i) the medical model;

(ii) the psychodynamic (psycho-analytical) model;

(iii) the behaviour model;

(iv) the social model.

The above models of mental illness were originally established in the hope that they would facilitate understanding of the concept of mental illness in terms of the identification of mental phenomena and treatment of mental disturbance. None of these models, however, have succeeded totally in providing a conclusive and workable definition and treatment procedure for mental disorders. The models are illustrated in the following pages.

In addition, throughout this chapter an attempt is made to highlight and analyse the problems of psychiatric diagnosis and terminology as expressed in the DSM-III. It is further argued that the adherence of the DSM-III to the medical model makes psychiatric procedures less responsive to the actual needs of individual patients with psycho-social problems.

In many cases, unfortunately, psychiatric diagnoses go far beyond the actual symptoms of patients and present a definitional image that is entirely different from the patient's actual condition. Moreover, as we have already established in Chapter Two, the current diagnostic terms in the DSM-III give the impression, to both clinicians and individual patients, of chronicity, irreversibility and long-lasting dehumanising effects. At best psychiatric diagnoses are a limited and inexact evaluation of the reality and uniqueness of individual psycho-social backgrounds, and at worst they can stigmatise and dehumanise a person for the rest of his life. Nevertheless, despite the many conceptual limitations of the concept of mental illness, many clinicians still adhere to the use of DSM-III diagnostic terms.

To avoid some of the problems outlined above, the present writer proposes to view mental illness as a Reactive Functional Disorder (RFD). This term emphasises the idea of totality in studying functional disturbances in that it regards mental illness as a total failure of the psycho-social and possibly the physiological functioning of the individual. The emphasis here is on the concept of abnormality

as related to functions and not just as unspecified symptoms. A full analysis of this model will be presented in this chapter.

The Current Conceptual Models of Mental Illness and the Problems of Explanation

From a historical and traditional perspective, the definition and hypothesis of mental illness has been established by social, theoretical and political forces which have led to the inclusion or exclusion of conditions such as homosexuality on political, social, and moral grounds rather than scientific ones, and to the formation of specific criteria as in the Soviet diagnostic system to incorporate many political dissenters (Szasz in After Dark, 1988). The models which are currently in use in the mental health professions are conflicting in the way they explain human behaviour because they are grounded on limited and often biased concepts of mental illness (Lazane, 1981). Many theories and models of mental illness have been developed, not on the basis of new experimental data in the field, but in the absence of new valid theories needed to dispute the current models of mental illness (Tyner and Steinberg, 1987).

As a result, the definition of mental disorder often reflects the principles and hypotheses of different schools and models which are difficult to refute. The disease or medical model, for example, regards mental disorders as a consequence of physical or chemical change in the brain or the body (although such organic basis has not been well established in many of the cases psychiatrists treat). Psychiatric intervention would consequently aim to cure

the underlying pathological disturbance and to "ensure a sense of wellbeing" (Peele, 1981, p.816). Another model in psychiatry is the psychodynamic model. This model could be identified by analysing the basic assumptions on which the psychoanalysis school is based. The psychoanalysis school put a great emphasis on making the inner mental process and the forces which interact with it more accessible to direct assessment (Skinner in Moore, 1984). This led Freud and many of his followers to emphasise the process of understanding and explanation of human behaviour as an expression of internal events rather than external factors. Freud's explanation of psychiatric disorders is based on the belief that environmental factors can stimulate the inner mental structures of the individual with disturbed behaviour. Such interaction between external factors and inner mental process would be manifested in the form of compromising symptoms (see Bloch, 1982).

However, the problem of psychoanalytical interpretation is that the association in the causal chain is not often clear or specific. In fact, in many cases such a link turns out to be misleading when external factors are 'remodelled' into 'conscious' and 'unconscious' experience (Skinner, 1953), terms which hinder rather than facilitate a genuine understanding of the complexity of human behaviour. This is a view which firmly places the individual at the mercy of his past conflicts and the forces of his repressed emotions or unhappy experience, thus depriving him of the power to determine his life through conscious thought, belief and action. For psychoanalysis "... there is nothing trivial in mental life" (Bloch, 1982,

p.69). In other words, human action and thoughts must be thought in terms of 'psychic determinism' (Ibid., 1982).

Behaviourists, on the other hand, believe that mental disorder is a learned behaviour which puts the individual in conflict with himself and society. Such inappropriate learned behaviour is the 'illness', not the pathology of the brain. The treatment plan, therefore, is to establish a new model of learning habits which replace the 'bad' learned behaviour. Such a view of mental disorder is useful in terms of problems that involve specific variables (e.g. phobias from specific objects). In severe mental illness, however, such behavioural learning procedures are not applicable because they are too simple and because treatment strategies based on the ideology of S-R are being applied in a simplistic and mechanistic fashion to human behaviour as if it (the behaviour) is something independent from the human. Moreover, S-R's ideology does not take full account of the immense variety of factors which contribute to the totality of individual experiences.

In practice, alcoholics do not stop drinking alcohol merely because of the application of aversive behavioural techniques (e.g. positive response to alcohol might be followed by electric shock as a negative reinforcement) (Ledermann, 1982). The theoretical aims of such behavioural techniques are to control and to reconstruct the negative or the 'weak will' of the patient. For behaviourists, the ability to decide or to act autonomously cannot be considered

as an effective variable in any estimation of whether the patient is capable of facing the problem or not.

The 'patient' for the behaviourist is a 'passive', 'deficient' and 'helpless' object (Fairbairn and Fairbairn, 1987) who occupies the role of 'patient' as a result of S-R correlation. In addition, the problem with the behaviourists' approach is their complete reliance on an impersonal machine-like approach in dealing with human problems. By applying methods and scientific procedures to the understanding and treatment of individual symptomatic behaviours, they are likely to ignore or undermine the subjective reality of thought, experience and an individual's systems of values (Walker, 1984). Whereas, as Walker (1984) argues, in reality an individual's "conscious thoughts and beliefs are among the most important determinants of their actions and behaviours, both in mental illness and in health" (p.146).

Finally, the social model of mental illness considers the influence of social and familial factors as an important element in the causation of mental illness. This model emphasises the role of pressure groups, cultural stereotype attitudes towards mental health, environmental factors (e.g. social and economic influences), and current experienced problems and social events. For the social model, the impairment is the result of an inability to fulfil role expectations or social norms. The treatment orientation of such a model, therefore, would be either to make changes in social and environmental factors or to consider the 'labelled' individual as

not really ill. For them, he is victim of a residual stereotyped concept of conformity which reinforces his role status as someone who is different from others and hence 'abnormal'. (For more details, see, Scheff, Lemert, Laing, Goffman.)

Clearly, these conceptual models in psychiatry are clear evidence of the problems psychiatry suffers when attempting to make sense of human behaviour.

Although not all the models outlined above share the same scientific status some models (such as the behavioural one) are considered to be more advanced than others because they are built on experimental grounds or they incorporate a large amount of case histories, they all seem to be, to different extents, inadequate in providing a sufficient explanation of abnormality (Gorenstein, 1984). This is because human behaviour is far too complex for any of the above models to establish a universal concept of mental illness.

The RFD model presented here was developed in the hope that it might fill some of the gaps, specifically, the moral perspective of psychiatric labelling, left by current conceptual model of mental illness, and perhaps help to shift some of the generally accepted perspectives on what constitutes mental illness.

It is our belief that mental illness cannot be as easily conceptualised in terms of a defect in one major function (e.g. organic or social or psychological or behavioural) but is best viewed within

the 'total' function of life. The models listed above attempt to highlight factors responsible for the patient's suffering, or the symptoms of such suffering. Such models tell us little, however, about the individual 'patient' as a whole in terms of, for example, his ability to function in spite of his suffering, or his ability to determine his own course of action, or his life in general. The resultant presumption is that the patient's symptoms or suffering constitute a major defect in his/her personality traits or an inappropriateness of early experience or some general and fundamental weakness in the patient's make-up. It seems, therefore, that no one model offers a sufficient and comprehensive explanation of the concept of mental illness. The models discussed above merely provide an interpretation of individual functional behaviour consistent with the principles and ideology which govern the logical structure of the model. In schizophrenia, for example, if the suffering is considered to be a manifestation of a pathological inner agent, the condition would be treated by physical means (the medical model). If, on the other hand, the patient's past family history or his inner conflicts are perceived as responsible for his problem, he would be transferred to a psychotherapist (The psychoanalysis model.) Finally, if his problem is interpreted as a reflection of inappropriate learning habit, token economy therapy would be viewed as the best course of action. (The behaviourist model.)

The above example shows that the psychiatric implications of such models are highly contradictory and that the patient might receive different and confusing messages. To illustrate the problems

further, consider the following case which was seen by the present writer. Ms N is a 28-year old single Kuwaiti woman, a lecturer at Kuwait University. She was convinced that she had lost control of her bladder and that her clothes were therefore permanently permeated with urine.

Ms N was a religious woman who prayed and fasted at the prescribed times and this was the basis of her problem. A praying Muslim must be 'Taher' or 'ritually clean'. This involves washing the hands, feet and the head before praying. Many things can make a person 'unclean' and therefore not fit for praying. These include the passing of urine, stools or wind, sexual intercourse or falling into a deep sleep. The case's main clinical feature was a mild depressive state because she often felt unclean due to her unrealistic but persistent idea that she was urinating in her clothes. Therefore she had to wash thoroughly before every prayer. If she accidentally splashed some water on her clothes, she would believe, upon noticing the wet marks, that the water had mixed with the urine on her clothes. If she sat down on chairs while in this state she believed the furniture itself became unclean and was anxious if her family sat on them lest they become unclean by contact and their prayers rendered invalid. This led the patient to engage in obsessive cleaning behaviour. This behaviour (washing her body, clothes and the furniture) lasted for two to three hours daily. Ms N had few friends and was unmarried. This is not considered normal in an Arabic country where women usually marry at an early age and have many friends of the same sex. Nevertheless, and inspite of her condition, Ms N was an accomplished

lecturer. Her mother believed that her daughter was suffering from irrational and illogical beliefs and she was very anxious about her. Eventually the mother telephoned the emergency room at the psychiatric hospital in Kuwait and asked for advice. The psychiatrist in charge advised her to bring her daughter to the hospital. As a result of the family pressures and psychiatrist's advice, Ms N admitted herself to the hospital. She had previously refused psychiatric help because she thought her problem would be regarded as insignificant by professionals. Moreover she thought it would solve itself. During the admission procedures, she was very embarrassed about her problem and felt ashamed that other professionals knew about it. After the routine evaluation, she was given a course of mild tranquillisers (Ativan 2 mg.) to help her cope with her obsessive behaviour (medical model). After two weeks she was subjected to brief psychoanalysis (psychodynamic model). According to the psychoanalyst in charge, her obsessive compulsive behaviour was due to feelings of guilt because of having masturbated ten years before. Two months later she was subjected to behaviour therapy (systematic desensitisation).

One year later the patient reacted negatively to her hospital experience. She isolated herself even further because of the stigma of being an ex-mental patient and eventually she took a long vacation from the university because she was unable to carry out her duties. The present writer recently received a letter from her in which she described how the admission procedures (the opening of a file, being issued with a card, etc.) had led her to fear that she was seriously disturbed. (It must be pointed out that the patient herself had

been aware, prior to admission to the hospital, that her belief and behaviour were irrational, but had hoped that her condition was not serious and would right itself eventually.) It seems that after treatment, her morale, far from improving, had deteriorated in that she felt unable to make decisions about her personal life any more and felt she needed psychiatric help for virtually all her current problems. Although Ms N's obsessive behaviour had obviously caused her a lot of suffering, 'suffering' in itself is not pathological. Suffering in bereavement, for example, is a justified emotional expression and not pathological. Ms N's mother and the psychiatrist in charge, however, presumed unhappiness as the basis for applying the concept of psychiatric disorder. The point which needs to be made here is that if happiness and unhappiness were to be used as yardsticks to measure the 'normality' of behaviour, then most of us would find ourselves in a psychiatric hospital at some time or other in our lives. The question, as Szasz (1973) puts it, is "what kinds of behaviour are regarded as indicative of mental illness, and by whom?" (p.15). It is wrong, Szasz maintains, to apply a general or a hypothetical term such as the concept of mental illness in the name of medicine, to problems whose very existence is not medical in nature. Thus Szasz rejects the inclusion of the concept of mental illness in the classification of a medically valid illness and instead he proposes 'problems of living' as an alternative concept.

Clearly, Szasz's position on mental illness conflicts with the medical model (Gorenstein, 1984). However, mental illness will not disappear and mental patients will not be cured by Szasz's arguments

(see Roth, 1976). In fact, as we mention in previous chapters, Szasz does not claim to provide mental health professionals with a workable, conceptually advanced alternative for the concept of mental illness. Rather, as we shall see in the following chapter, he presents an ethical account of the concept of mental illness.

The above case shows clearly that mental health professionals are not always able to provide a convincing and logical answer to many human problems or personal difficulties. Problems emerge when mental health professionals, in spite of their clinical limitation, promise virtually every individual patient that there is always a psychiatric clinical answer to his problems, regardless of whether the presented complaint is relevant to psychiatric expertise. In reality, mental health professionals cannot always keep their promises because of the inherent limitation of their field and can merely give logical answers for their failure. For that reason, clinicians often put a great emphasis on the contributory effects of unintelligibility and irrationality in individual behaviour, rather than the ability of the individual to function in spite of his suffering. This may well be a way to conform their role status as reliable clinicians who have the ability and the professional knowledge to detect 'pathological' mechanisms underlying the 'illogical' behaviour (Price and Denner, 1973; Schatzman, 1972; Farrell, 1979).

In psychiatric practice in general there are a number of patients who are diagnosed as psychiatric cases although their problems might be moderate, adjustable problems which are generally shared

by others who make an effective adaptation without any kind of psychiatric intervention. Infrequent, mild delusions or occasional feelings of depression or anxiety may interfere little or not at all with the psycho-social functioning of the individual (see Berke, 1977). However, the clinician "may impute undue significance to particular symptoms that occur commonly and that are self-limited" (Shepherd, M. et al in an Editorial Paper presented at the 72nd Annual Meeting of the A.S.A., 1978, p.385). That is because the psychiatrist needs to protect his image as a clinician who can easily judge the abnormality of any given behaviour. Moreover, not validating the patient's personal claim of his problem or the family's report of distress would upset both the patient and his family and eventually questions regarding the physician's professional validity and the efficacy of psychiatric services in general would be asked.

In fact, many mental health professionals believe that accepting and confirming the patient's personal claim of distress has a positive therapeutic benefit such that the individual whose "complaints, worries or fears have appeared unreasonable and irritating to those around him, finds some sympathy and understanding after illness has been diagnosed and treatment begun" (Miles, 1987, p.203).

Thus psychiatric procedure "produces a bias toward over-treatment, subjecting some patients unnecessarily to risks of iatrogenic illness and stigmatisation" (an Editorial Paper presented at the 72nd Annual Meeting of the A.S.A., 1978, p.385). Instead of stimulating the individual's willpower to cope with life's stresses, the

clinicians may have emphasised trivial symptoms stressing the belief that there is some sort of impairment residing inside the individual. The problem of psychiatric abuse occurs when the psychiatrist, in addition, feels some sort of obligation to find 'anything' that can count as disturbance in the patient, in order to reinforce or validate the family claim of illness without any regard to the patient's general ability to function in spite of his problem. A possible explanation for this kind of practice is that when the psychiatrist faces an overlapping and unspecified symptom, this might cause him an embarrassment in front of his colleagues or in the presence of the patient's family or the police, etc., through failing to relate the symptoms to a plausible interpretation or diagnostic criteria, this would create doubt regarding the validity of what he learned or his clinical skills in general. Such dilemma might lead the psychiatrist to ignore or misperceive vague symptoms, or he might hold an episodic phase of disturbance as a positive indication of impairment. Ms N, for example, was able to carry out most of her daily duties effectively in spite of her obsessive compulsive behaviour. Szasz (1973) refers to cases like this by arguing that individual patients are rational and aware of themselves and the environment around them. Such an awareness, Szasz believed, must not be ignored.

As already established, psychiatric diagnosis and treatment depend on the model of mental illness to which the mental health professional adheres, the nature of therapeutic relation between professionals and patients, his personal experience, the institutional norms, and whether the patient is motivated for the therapy or not

(as the amount of available data for evaluation will be relatively small if the patient is not motivated). Such variables interfere with the psychiatrist's ability to interpret and conceptualise the individual's problem and may lead to misinterpretation. To illustrate the above points, and the problematic nature of the concept of mental illness in general, consider the following case which was interviewed by the present writer. Mr. B is a 21-year old single Kuwaiti man who was a student and had a good part-time job in the Ministry of Information in Kuwait. Two years ago, while in the last year of secondary school, he became attracted to another male student. This student was good looking, articulate and popular with the other boys in the school. Mr. B was lacking in such characteristics, which was largely due to his disturbed family background. His father was a cruel, over-protective man who isolated his children, refusing to let them mix with others, and frequently punished them if they disobeyed him. Mr. B admired Mr. A and subsequently he established a friendly relationship with him. Gradually he became more and more attached to him, to the extent that he started feeling jealous if he saw Mr. A talking to another boy. He shared his problem with Mr. A. The two boys would meet socially outside school hours, eating, drinking and talking together. Mr. A accepted the relationship as a normal school friendship. When they finished secondary school, Mr. A went to the University of Kuwait to study English. Mr. B did the same in order to be near Mr. A even though he had no interest in English. At this stage in the relationship, Mr. A began to withdraw from Mr. B because he was becoming worried by the intensity of the relationship. Mr. A did not want to be seen at university

to have a clinging male companion. Mr. B sensed his withdrawal and his academic performance and family relationship began to deteriorate as a result. Mr. B's father contacted a friend who is a psychiatrist in the hospital for help. Under the combined pressure from the family and the psychiatrist, Mr. B agreed to admit himself to the hospital. On admission the psychiatrist diagnosed him as 'homosexual' and advised him to stay away from Mr. A. Mr. B began to feel that his relationship with Mr. A was considered immoral and 'dirty', and eventually became depressed and frustrated. He was eventually referred to the present writer for psychotherapy. From subsequent sessions, it transpired that Mr. B believed he had found in his relationship with Mr. A the love and understanding that was lacking in his family. It was from Mr. A that he learned how to talk to others, how to dress appropriately, etc. However, the psychiatrist in charge, with the co-operation of a psychologist, interviewed Mr. A and advised him to disassociate himself from Mr. B due to the 'threat' of a possible 'homosexual' motivation on the part of Mr. B. Mr. A has now left the university and has gone to the United States to study English (in order to escape from Mr. B!). The case felt that he had been mis-diagnosed, and that his life had been ruined by the suggestion that his deep friendship was somehow 'immoral'. As a result he has become very depressed.

While examining his file, the writer discovered that Mr. B had been given more than one diagnosis. The first one was 'homosexual' accompanied by 'depression', the second diagnosis was 'simple schizophrenia' (due to disturbance in his work and family relations, withdrawal symptoms, emotional disturbance and hypochondria). Accordingly,

he was subjected to twenty sessions of ECT as well as a course of anti-psychotic medication. The present writer could find no symptoms of simple schizophrenia in the case. During the interview, Mr. B told the writer that he had none of the problems listed above before 'psychiatric treatment'. He thought that his friendship with Mr. A had been misinterpreted and accordingly he developed a reactive depression.

Before the psychiatric treatment, Mr. B had conducted his life in an effective way. He had been an average student at the university, had driven a car, planned a future that included marriage. Now he felt his life had fallen into pieces. The university dismissed him because he was absent for one year. He started having problems at work and had several car accidents.

It is obvious from the above case that the diagnosis of the clinician involved was based on the subjective moral belief that deep friendship between the same sexes is unnatural and leads to emotional disturbance which requires psychiatric intervention.

Dr. Ewald Busse in Bloch and Reddaway (1977) has summed up the above point clearly by arguing that psychiatry should not be in the business of determining human values.

In dealing with cases such as Mr. B, it is necessary for mental health professionals in general to consider the concept of 'neutrality' in their diagnosis and treatment plans (Plog and Edgerton,

1969; Wear, 1980; Gorenstein, 1984; Fabrega, 1987). Psychiatrists must be unbiased and impartial towards moral and personal issues. The professional ability of psychiatrists to impose their decisions must be done without denying the right of Mr. B, for example, to expect a decision relevant to his total life. In many psychiatric cases the problem arises when the patient's behaviour is interpreted in terms of moral appropriateness. Moreover, the psychiatrist tends to judge the 'psychiatric patient' within the general framework of psychiatric efficiency standards. However, in many psychiatric cases, it is difficult to define objectively or accurately the efficiency of behaviour because the concept of efficiency as related to any given behaviour is in itself a value-laden term. For some psychiatrists, incompetent behaviour would imply non-conformity or residual deviation (troublesome behaviour for example), while others interpret inefficient behaviour as behaviour which escapes any standardised norm of evaluation or prediction, therefore constitutes a threat to the individual himself or society in general (e.g. bizarre behaviour, suicidal threats, etc.).

The question which arises from the case illustrated above and the discussion which followed is this: was the functional or behavioural effectiveness or efficiency of Mr. B diminished or increased by psychiatric treatment? In fact, as pointed out earlier, Mr. B's mental health noticeably deteriorated after the psychiatric treatment due to the fact that many mental health professionals had under-estimated or ignored the content, purpose, and meaning of his behaviour by interpreting it in sexual terms. The official diagnostic manual

of the APA - DSM-III was established in the hope that symptomatic behaviour could be specified in objective and clear-cut norms, but it has failed to do so because of the many controversial issues regarding the problematic nature of the concept of 'mental illness', i.e. because symptomatic behaviour implies abnormal vis-a-vis normal. The question of what is exactly normal or abnormal, and for whom, and many other related problematic issues need to be specified accurately before any proposed definition of what constitutes "symptomatic behaviour", and hence psychiatric disorder can be established. In saying that, one must bear in mind that the individual's psycho-physio-social functions are inter-related and interact in their total methods of operation, and differ greatly in degree in different ways. Therefore, diagnosis of any disturbance in these functions must acknowledge the "interlocking and graded nature" (Farrell, 1985, p.5) of such functions. Accordingly, it is difficult to appreciate any attempt to classify individual disturbed functions in "separate boxes" (as analogous to physiological functions) as in DSM-III and many classification schemes (Ibid., 1985).

DSM-III and the Concept of Mental Illness: A Conceptual Analysis

The nature and structure of DSM-III

This manual, published as DSM-III in 1980, was later modified on its third edition (DSM-III-R). The manual has been established in the hope that it will facilitate communication among mental health professionals, for the keeping of statistical records on the occurrence of several types of individuals' problems, and for planning treatment.

As we have already established, many of these aims have not been reached.

The manual is basically oriented towards the description of the individual's suffering rather than explaining it in terms of causes. In fact, DSM-III-R encourages psychiatrists to depend heavily on 'impressionistic' clinical judgement or their experience (e.g. when estimating the severity of a disorder) (Sarason and Sarason, 1987, see also Rey et al, 1987; Spitzer, 1985).

Another characteristic of the manual is its use of a multi-axial system. This means that no patient will be classified into a single category, instead the definition will be in the form of a group of symptoms that are distributed in five axes:

Axis I: incorporates "clinical syndromes, conditions not attributable to a mental disorder that are a focus of attention or treatment" (e.g. fear of heights) (Quick Reference to The Diagnostic Criteria from DSM-III, 1980, p.5).

Axis II: involves personality disorders and developmental disorders;

Axis III: involves physical disorders that are relevant to the psychiatric condition (the patient's previous history of some sort of chronic physical disease, for example);

Axis IV: provides a rating of the severity of psycho-social stresses that are defined as being significant in the development of the disorder (e.g. divorce, traumatic accidents, etc.);

Axis V: permits the psychiatrist to make an evaluation of the individual's highest level of adaptive functioning during

the past year. (The DSM-III specifies adaptive functioning as three major areas: social relations, occupational functioning and use of leisure time) (Ibid., 1980, pp.5-17).

DSM-III and the Concept of Mental Illness

There would be little doubt that a newly graduated psychiatrist would probably view Mr. D's over-spending behaviour (see Chapter 2) as representing a "gross impairment in reality", or "incorrectly evaluates the accuracy of his or her perceptions and thoughts", or "incorrect inferences about external reality", etc. (DSM-III, p.404).

Such a description of Mr. D's general psychiatric condition is obviously based on the assumption that the concept of 'reality' can be either 'correct' or 'incorrect' - and that mental health professionals are adequately equipped to judge such distinction.

In order to validate the above description of Mr. D's spending behaviour, psychiatrists use a highly technical term - which is not, in fact, very different in nature from terms used by the lay public. That is to say, instead of describing Mr. D as 'mad', 'bad', or 'wrong', a psychiatrist would use terms such as 'illogical' or 'irrational' thinking or similar words. 'Bad' in clinical terms would be 'incorrectness of perception or evaluation'. 'Wrong' in the psychiatric formula would mean 'inappropriate' or 'incompetent' act. Such descriptions whether made by the public or psychiatrists do not provide a detailed personal account of a case like Mr. D.

Accordingly, one wonders how pyschiatrists can ever be sure of their judgemental accuracy of the significance of, for example, Ms N's unrealistic and persistent idea that she was urinating in her clothes, or the clinical reality of Mr. B's deep friendship with Mr. A.

No such assurance can be attained because the nature and content of the cognitive and motivation system or the psychological machinery underlying behaviour is simply not yet well understood.

In reality, only Mr. D, Ms N and Mr. B can know exactly the boundaries of their suffering and their true abilities and limitations to face their present problems. "The scientific enquiry may help us to understand some of the mechanisms by which an experience [of Mr. D, Ms N and Mr. B] occurs; it tells us almost nothing about the experience itself. For the experience is not happening in the brain ... but in a person and a person is far more than the sum of his biological system" (Runions, 1984, p.224). Thus, current psychiatric diagnostic procedures still suffer from methodological problems of validity and reliability when attempting to evaluate the subjective experience or the significant motivation of behaviour of the individual 'patient' by "objective" and "accurate" methods.

In many cases, the psychiatrist goes far beyond the actual symptoms of the patient to something else. In other words, the psychiatrist can translate many minor problems of behavioural conduct far beyond the actual limits of such problems (Straus et al, 1969). Consider, for example, Mr. B's close friendship with Mr. A when taken

as an indication of homosexuality. Another example would be Mr. D's spending behaviour to the poor which presumably is viewed by the admitting psychiatrist as a sign of 'psychosis'.

In other words, the psychiatrist's definition of the patient's symptoms lacks, in many instances, an accurate perspective and that is why psychiatrists tend to use in their diagnostic schemes terms such as "the person is more likely to ...", or "he is nearly ...", "often", "almost", "some", etc. (e.g. the depressed patient "is likely" to commit suicide "if"...) (Robins and Helzer, 1986), or to support their terms by using statistical explanations which are more convincing to the public and other medical societies (Gove, 1982). Such terms show clearly how the psychiatrist's definition of the patient's present symptoms have a low level of probability. Such a low degree of probability can be seen evidently when one considers the presence of different overlapping criteria and ill-described categories in the DSM-III, such as "undiagnosed psychiatric illness" or "atypical disorder" (Robins and Helzer, 1986) which indicate the residual category of the disorder. Furthermore, the presence of exclusion criteria in DSM-III such as the phrase "not due to" creates many practical problems because it is very difficult to define exactly in terms of an operational manner how one disorder can emerge or be separate from other disorders. Depression, for example, cannot be established easily as being 'caused by' phobia (Boyd et al, 1984). Such terms make the concept of mental illness more vulnerable to abuse by mental health professionals. The process of abuse begins with cases such as Mr. B in which his 'close friendship' symptoms do not accurately

satisfy the precise criteria of DSM-III and therefore the psychiatrist is free to designate Mr. B as in the category of "unidentified psychiatric disorder" (Ibid., 1984) or any such psychiatric description.

Moreover, Mr. D's response to a command from the Gospel can be viewed as having 'paranoid personality disorder' or 'paranoid schizophrenia'. That is to say that the limits between such disorders are blurred because the concept of the above disorder and many psychiatric labels are not totally comprehensible or consistent in their view of the different forms of human suffering (Gorenstein, 1984; Monroe, 1982).

Pushing the argument even further, let us quote the description of "schizophrenic disorders" criteria, as it appears in the DSM-III, in order to get a clear picture of how difficult it is to conceptualise mental illness in clinical practice:

A. At least one of the following during a phase of the illness:
   (1) bizarre delusions ... such as delusions of being controlled, thought broadcasting, thought insertion, or thought withdrawal;
   (2) somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content;
   (3) delusions with persecutory or jealous content if accompanied by hallucinations or any type;
   (4) auditory hallucinations in which either a voice keeps up a running commentary on the individual's behaviour or thoughts, or two or more voices converse with each other;
   (5) auditory hallucinations on several occasions with content of more than one or two words having no apparent relation to depression or elation; (this criterion is in itself bizarre, it could include almost anyone);

(6) incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech is associated with at least one of the following:
(a) blunted, flat or inappropriate affect;
(b) delusions or hallucinations;
(c) catatonic or other grossly disorganised behaviour.

B. Deterioration from a previous level of functioning in such areas as work, social relations, and self-care.

C. Duration - continuous signs of illness for at least six months ... The six-month period must include an active phase during which there were symptoms from A, with or without a prodromal or residual phase, as defined below:
Prodromal phase - a clear deterioration in functioning before the active phase of the illness not due to a disturbance in mood or to a Substance Use. Disorder involving at least two of the symptoms noted below.
Residual phase - persistence following the active phase of the illness of at least two of the symptoms noted below not due to a disturbance in mood or to a Substance Use Disorder.
Prodromal or Residual Symptoms:
(1) Social isolation or withdrawal;
(2) Marked impairment in role functioning as wage-earner, student or homemaker;
(3) Markedly peculiar behaviour (e.g. collecting garbage, talking to self in public, hoarding food);
(4) Marked impairment in personal hygiene and grooming;
(5) Blunted, flat or inappropriate affect;
(6) Digressive, vague, over-elaborate, circumstantial, or mataphorical speech;
(7) odd or bizarre ideation or magical thinking, e.g. superstitiousness, clairvoyance, telepathy, "sixth sense", "others can feel my feelings", overvalued ideas, ideas of reference;
(8) unusual perceptual experiences, e.g. recurrent illusions, sensing the presence of a force or person not actually present.

D. The full depressive manic syndrome (criteria A and B of major depressive or manic episode), if present, developed after any psychotic symtoms,

or was brief in duration relative to the duration of the psychotic symptoms in A.

E. Onset of prodromal or active phase of the illness before age 45.

F. Not due to any Organic Mental Disorder or Mental Retardation.

(Quick Reference to the Diagnostic Criteria from DSM-III (Mini-D), pp.103-106)

However, it is questionable whether all of the above criteria or symptoms have to be present when making a diagnosis. The presence of some would be a sufficient condition for labelling someone as schizophrenic. The problem, however, is that even a selection of the above symptoms is very rarely found in a single individual patient. Moreover, the psychiatrist may have noticed only some of the symptoms mentioned above because the patient did not manifest the others at the time of the interview. In fact, only a limited number of patients show the classic 'textbook symptoms' (Townsend, 1980).

Thus, few psychiatrist would hesitate to view Mr. D's spending behaviour as an indication of impairment in his social functioning, as bizarre delusions (command from the Gospel), and odd thinking. Thus, he is schizophrenic. In fact, mental health professionals have the ability to label any individual as schizophrenic. Ms N's irrational behaviour, for example, might be considered by some psychiatrists as implying the presence of thought disturbance. Therefore, Ms N too might be diagnosed as 'schizophrenic' or vulnerable to schizophrenia, or she might suffer from 'latent' schizophrenia.

Our final example is Mr. B whose close friendship with Mr. A implies the presence of emotional disturbance or "inappropriate affect" and whose present deterioration in social functioning (e.g. work and school achievement) is taken as an indication that he is 'schizophrenic'.

In DSM-III it is quite possible for the 'clinician' to diagnose Mr. B as schizophrenic in the absence of hard evidence of any deterioration in his total functioning. Mr. D was presumably admitted to the mental hospital on the basis of a single reference that represented auditory hallucination (command from Jesus). Mr. B and Ms N were admitted on the basis of their family claim when the families reported that their children suffered from strange behaviour, even though all the above cases show an acceptable level of functioning in their total life.

In many cases, even if the individual manifests a simple deterioration in his social functioning, but is able in one way or another to manage to function in an acceptable standard within his work, satisfying his biological needs and so on, psychiatrists still tend to consider that such partial deterioration in his social functioning is a signal of a more general and significant deterioration in his total functioning which is bound to occur in due time (e.g. Daithesis - stress theory which implies a genetic vulnerability to schizophrenia).

Wing (1978) summarises the above discussion by stating that some psychiatrists "may be much more ready to apply labels such as 'schizophrenia' because some aspects of attitude or behaviour is socially unintelligible or out of touch with reality" (p.246).

The question which needs to be asked here is: "How is the psychiatrist capable of deciding that the present deterioration is more significant than his previous level of functions?" Could it be that Mr. B or Mr. D's present level of functioning is much better than their previous one? (See criterion 'B'.)

Related questions concern the ability of mental health professionals to estimate with confidence the patient's previous level of functioning and the availability of special or independent psychiatric tests for detecting the patient's previous and present level of functioning.

A careful analysis of criterion 'B' would give the impression that there is an internationally agreed standardised scale of functioning in certain ways and that any departure from this would be considered an abnormal state.

An examination of Axis IV, for example, would reveal that the "DSM-III specifies no particular procedure for eliciting information about stress or occurrence, and although it provides a list of examples it would be unrealistic to suppose that this list is systematically used ..." (Rey et al, 1988, p.288).

Why is Axis IV not used systematically by mental health professionals?

Studies cited in Rey et al (1988) establish that the definition of what is considered to be a significant stressor in any psychiatric interview is 'sporadic' and 'idiosyncratic' (Paykel in Rey et al, 1988).

Research (see Chapter 2) also reported that the raters in different cultures might formulate different understanding or rating when confronted by different events. Thus what counts as aetiologically significant for a Kuwaiti psychiatrist might not be so for a British psychiatrist. That is to say that there is no accepted guideline for obtaining the relevant data.

It must be clear that psychiatrists do not have a special instrument for deciding objectively and precisely the abnormality of any psychiatric condition in a reliable way. The DSM-III solution to the above problem is to encourage clinicians to use their experience or their commonsense when rating the individual's previous level of functioning and the severity of the stressor, or by creating certain exclusion criteria as in criteria (F). The main purpose is to solve the problem of psychiatric uncertainty as to which of the major psychoses is present (Monroe, 1982), and to give the clinician more flexibility when judging the presence or absence of abnormality.

It would appear, therefore, that when psychiatrists agree with each other to use one specific label that does not mean necessarily

that the label is accurate. Consider Rosenhan's study which was quoted in the previous chapter. All the psychiatric staff in the hospital agreed that the volunteers were schizophrenic and all of them were wrong. This obviously prompts us to question the validity of much psychiatric diagnosing.

Nevertheless, and in spite of the above limitation of the DSM-III, the manual equips its practitioners with unlimited authority in the form of "linguistic dominance" (Schacht, 1985) which helps them to promote a total compliance with their decisions. Furthermore, such a diagnostic manual provides the clinicians with a powerful medical status which enables them to impose their authority and supervision on every aspect of a patient's life (e.g. his competence to make a contract, the denial of the individual's right to be autonomous through compulsory hospitalisation, separation of parents from their children, etc.) (Schacht, 1985).

The problem occurs on a large scale when one considers the fact that such "linguistic dominance" has given mental health professionals a false impression that they actually understand mental functions or psychological machinery. Another related problem is that many mental health professionals tend to believe that the information they obtain from the patient and his behaviour is reliable evidence of his total personality rather than a result of different factors such as the situation and context in which the patient finds himself, or the nature of interaction between him and a nervous psychiatrist or adminsitrative staff, or the role of subjective meaning

and value, which the patient attaches to his problem. Such factors might lead to a significant distortion in the collected data. That is to say, mental health professionals do not deal in reality with 'a schizophrenic' but rather with an individual who might have schizophrenia.

What mental health professionals need is a method of analysis which is not confined to one aspect of the individual's abilities to face the problem but is oriented towards the individual's total life and functioning as it is perceived by themselves.

One possible alternative would be to view mental disorder as a reactive functional disorder. A full account of this approach will now be discussed.

The Reactive Functional Approach and the Concept of Mental Illness

Throughout this chapter the term "Reactive Functional Disorder - RFD" will refer to a temporary reactive 'total' failure in all the individual's major psycho-physio-social functions, which merits psychiatric intervention.

The term 'reactive' is used here to mean the individual's reaction to external rather than internal processes. 'Functional' here refers to the three major levels on which an individual conducts his life, i.e. the psychological, the physiological and the social.

(A detailed analysis of these functions will be examined through different parts in this chapter). Each of the above functions must be fully deteriorated and the overall disintegration must be significant to a degree that signals the individual's call for help.

The RFD model was developed to deal primarily with cases suited to psychotherapy rather than with severe forms of psychosis.

As already mentioned, in most circumstances, the RFD model incorporates the patient's own judgement of the degree to which his major functions have deteriorated. This reference to the patient's own interpretation represents an important step away from the dangerous reliance, in the DSM-III model, upon psychiatrists' subjective interpretation.

To illustrate the above definition and other related terms, it would be much more convincing if we examine the following case illustration which was interviewed by the present writer in 1982.

Mr. M is a 28 year old single Kuwaiti man who works as school social worker. At the age of 8, while he was in the last year of primary school, he was attacked on his way home by a couple of 15 year old boys who badly beat him up, and then raped him. Mr. M was extremely distressed by the experience, but was ashamed to tell anyone because of the stigma attached to being raped. Subsequently, he became excessively fearful of becoming the object of another attack and had to be taken to and fetched from school by his family on the

pretext that he was feeling tired or unwell. Another expression of his extreme anxiety was his sudden refusal to eat anything sweet, even though he had a very sweet tooth, because he did not want to put on weight (his family had always told him that he looked more handsome when he was fatter, and he was afraid that his good looks might provoke another sexual attack).

At the age of 19, when he was in the last year of secondary school, he joined an extreme Islamic group and three months later he started to behave in an obsessive manner. For example, the customary pre-prayer wash would take him one hour instead of the usual two minutes, and he would pray twice as long as it was customary. A couple of years later, he developed obsessive anxieties about driving his car. Every time he got home at night he worried that he might have run someone over and would retrace his journey looking for the body.

At the age of 27, Mr. M developed an obsession about having been infected with the AIDS virus during a sexual relationship two years previously, and started to interpret minor illnesses as symptoms of the disease even though his doctor had told him that there was nothing seriously wrong with him.

Now let us imagine a hypothetical situation where Mr. M is arrested by the police one night while searching for the 'body' of the person he imagines he has run over. During the investigation procedure conducted by the police, Mr. M admits to his fears, and

the police eventually refer him to a mental hospital for a decision as to whether he is mentally disturbed or not. There is very little doubt that, having been referred to a mental hospital in Kuwait, Mr. M will be diagnosed as 'mentally ill', either suffering from 'disturbed thoughts' (schizophrenia) or from obsessive-compulsive neurosis. Having labelled Mr. M and having assigned him to the 'career' of mental patient, the psychiatrists would then proceed to interpret all his subsequent behaviour as a symptom of this illness. So, for example, a query on the part of the patient regarding treatment, or an application to be discharged, or even just a request to see the doctor in charge, would not be taken seriously because the patient would be regarded as lacking the necessary insight for making a rational decision. Even significant improvements in the patient's condition would not be taken seriously because at the end of the day, Mr. M is the victim of incurable conditions which render him vulnerable to different relapses in his life. Moreover, by labelling Mr. M as 'mentally ill' - obsessive-compulsive, for example - psychiatrists focus on just one aspect of this person's total life functioning and, by doing so, completely disregard the individual's overall capacity to function effectively, and to live a positive life despite his problem. What psychiatrists fail to acknowledge is that personal suffering can in some cases have a positive contribution to the development of the individual's self-esteem and his personal growth, and as Frankl (1967) points out:

> "Even a man who finds himself in the most dire distress - distress in which neither activity nor creativity can bring value to life, nor experience give meaning to it - such a man still

> gives life meaning by the way and manner in which he faces his fate, in which he takes his suffering upon himself." (p.127)

It is a sad fact that the ability of a patient to live with his problem would very probably be viewed by clinicians as an expression of his 'disturbed' personality - escaping the unresolved conflicts of his unconscious by over-compensating (devoting all his energies to his professional life). In this way, the power of the patient's will and his self-determination to live with his problem and be in charge of his own life, is completely discredited, which in turn demeans and devalues the whole meaning of the individual's life, and creates feelings of weakness and dependence on the part of the 'patient'.

Thus, one is compelled to question the practical benefit of applying a concept such as 'mental disorder' to Mr. M's efforts to live his life in the best way he can. Is the purpose to help Mr. M achieve more positive goals than he has already achieved? Or is the aim merely to provide a psychiatric diagnosis for the hospital records, without any regard for the effects such a diagnosis might have on the individual? In fact, the process of railroading Mr. M to a mental hospital raises questions about his mental competency. It seems that the very fact that Mr. M was brought to the mental hospital by the police would be considered in itself a sufficient proof of his disturbance, and if he rejects psychiatric definitions and refuses to be admitted, his behaviour would, invariably, be interpreted as a sign that he is too ill to appreciate the help of the psychiatric services.

Analysis of the above case, according to the RFD model, would reveal that although the case was obviously malfunctioning on the psycho-social level, failure in functioning was only partial, as the case had managed to lead a full and successful professional life, and although aware of problems in personal relationships, was in general happy with his life.

Clearly, the present model is based on the assumption that a total, not a partial, failure of the individual's major functioning is a necessary condition for psychiatric intervention. Thus, it is crucial to draw a distinction between total functional failure on the one hand, and partial failure on the other.

Total Functional Failure can be identified when the patient or in most cases 'significant others', have observed a radical inability to function adequately due to the total disintegration of the psychological and the social function. A failure of the physiological function, however, would receive a somewhat different consideration. Although such failure could occur as a result of failure in the pscyho-social functioning, there are certain cases, for example psychopaths, where a breakdown on the psycho-social level does not necessarily result in failure to function on the physiological level. The RFD model, therefore, accepts that in certain cases, failure on the physiological level is not a necessary condition for the application of RFD. However, one must be clear about the actual contributory effects of the physiological function in any analysis of the individual's total functioning.

A central feature of total functional failure is the complete disturbance and disintegration of motivational, social, cognitive, and perhaps physiological abilities. At this stage 'others' rather than the individual himself, are more likely to initiate the 'call for help' or action procedures.

Partial Functional Failure can be defined as a state in which the individual continues to function adequately on the three major levels, but acknowledges certain limitations in his ability to function fully effectively. People who suffer from partial functional failure are on a continuum of what is accepted as normal since most individuals experience a different degree and quality of suffering throughout their lives. Total functional failure, on the other hand, represents an extreme point on this continuum, but can be viewed as a temporary deviation from a more moderate position on the continuum.

A point which needs to be emphasised here is that the 'patient's' self acknowledgement or self-referral might indicate in a relatively sufficient manner the degree of functional failure, i.e. partial or total.

The most salient feature of the above definition is the emphasis on the individual's own decision to seek help for his suffering. The present writer's experience in the psychiatric hospital in Kuwait shows that a great number of patients do not ask for psychiatric help unless their suffering becomes intolerable and their mechanisms of control begin to collapse. This reluctance is mainly

because of the stigma attached to being a psychiatric patient, and because of the view held by many people that mental problems are not serious because they do not usually affect one's body, or that they are 'imagined' anyway and probably also because of the negative attitude held by the public towards psychiatric services in Kuwait generally. Thus, when an individual does apply for psychiatric help, that must indicate that his suffering has become unmanageable, even if at the onset the problem has been only partial.

However, self-seeking help behaviour does not necessarily suggest accurately the degree of functional failure, whether partial or total failure. In fact self-referral itself might be a culturally defined notion. In the United Kingdom, for example, self-referral would be a sign that the patient did not have a total functional failure. In Kuwait, however, as in many other countries in the Third World where long-term suffering is considered not to be pathological, self-referral would be regarded as a last resort after the failure of every possible traditional alternative. In this case, self-referral in such countries might be taken - in certain psychiatric conditions - as a sufficient manifestation of a real failure in the patient's major or total functions (see Ben Tovim's study in Botswana (1985) which was discussed in the previous chapter).

Surely accepting the individual's own assessment of his/her inability to function on the psycho-physio-social level, (George Herbert Mead in Weinstein, 1983; Szasz, 1972) does not necessarily mean that - in Szasz's terms - 'other definition' do not determine

the sick role in many psychiatric conditions. A third party's claim, therefore, cannot be ignored in deciding the career of mental patient. However, significant others report must be examined and studied carefully before making a decision as to whether the individual's functional efficiency has totally failed (Fernando, 1988). The limitations and arbitrariness of the third party claims has been discussed in detail throughout this thesis.

The RFD model, nevertheless, emphasises the importance of the individual's claim which could be considered in certain psychiatric conditions as an appropriate criterion concerning the severity of his problem. In many cases, the patient himself is aware of his functional limitations, and feels the need for psychiatric intervention. A detailed analysis of the value of the individual's personal claim will be discussed in the following chapters.

Adherence to this principle, on the part of mental health professionals should lead to a significant reduction in involuntary psychiatric hospitalisation. Furthermore, a patient who has voluntarily sought psychiatric help is much more likely to benefit from such treatment because he is obviously motivated to improve.

A full account of the principles of the claims requirement and its limitations will be discussed in Chapter 5.

As mentioned previously, a related major concern of the RFD model is its emphasis on individual functional behaviour as a

'whole', or the concept of totality as largely derived from the work of Ernst von Feuchtersleben, a nineteenth century Italian psychiatrist who viewed mental illness as a defect in the "psycho-physical totality of man". Accordingly, the treatment plan must involve a social as well as a medical perspective (Ernst von Feuchtersleben in Laor, 1982). Karl Jasper (representing the existential view) has discussed the concept of studying the "man as a whole" as the basic principle of psychopathology. Jasper believes that it is crucial to evaluate the individual conscious experiences by using the following procedures:

(i) obtain an accurate 'understanding' of every aspect of the individual's life;

(ii) establish the importance of the interlocking and inter-related nature of the individual's problems, and how such problems can relate to other 'phenomena identified'.

To do so, Jasper believed that the mental health professional must use the patient's own description of his life and then by 'actualising' and appreciating such details, the clinician as a result can define and classify the phenomenon. Jasper called the above procedure "descriptive phenomenology".

Gestalt therapy also focuses on the importance of the "whole" personality in the practice of psychotherapy.

Finally, Aubrey Lewis (1953), in his essay "Health as a Social Concept", discusses the importance of the evaluation of the patient's "total performance" as a necessary condition for the diagnosis of mental illness. Implicitly, Lewis viewed such total performance

in its malfunctioning analogy to the disturbance of organs such as the heart.

Obviously, the work of the authors mentioned above emphasises the understanding of the person as a total human being which is a crucial factor in understanding psycho-pathology. The work of the above writers, however, does not fully explain how certain individual functions could be affected by a person's psychiatric condition, and by the moral consequences of psychiatric definition as it bears on the patient's moral agency.

The present approach is based on the concept of totality as it relates to individual total functional failure. The model of RFD aims to alleviate the problem of psychiatric abuse by viewing mental disorder as a reaction to or a result of external events rather than an internal residual event with unknown organic factors or caused by unconscious forces (a view developed by radical behaviourist - see Fairbairn and Fairbairn (eds), 1987). That is not to say that the 'external' events are free from evluative elements, or to deny the possibility of organic aetiology of mental illness. But these physiological elements are not yet fully understood and thus cannot generally be established as a causal agent for mental illness. (Recent research conducted by Dr. Hugh Gurling of the Middlesex School of Medicine at the University of London suggests that there is evidence linking schizophrenia and abnormal functioning as a cluster of genes on a part of chromosome 5. Another group of researchers, however, have found no such link (I.H.T. Friday, Nov.11, No.32, 881, 1988).

Our argument, however, is that the degree of judgemental accuracy of observable external events is much more significant than hypothetical inner mental states. This is because it is relatively easier to conduct systematic analysis and research on external variables and behaviour - an approach which would minimize the effect of subjective variables. Systematic analysis can be done by collecting data on the observable factors of which behaviour is a function and by many other methods of observation (Skinner, 1987).

It is important at this point to state that the basic hypotheses and concepts of the RFD model have, to a certain extent, been inspired by the following writers:

1. The radical behaviourists, such as B.F.Skinner, who hold the view that human problems must be explained in terms of an environmental rather than a mentalistic or physiological account;
2. The radical psychiatrists, psychologists and sociologists, such as Tomas Szasz, R.D.Laing, Albert Ellis, Leiffer, David L. Rosenhan, Theodore Sarbin, Fulley Torrey, Goffman, etc. All the above writers have contributed by raising many problematic issues regarding the rights of mental patients, the validity of the concept of mental illness and psychiatry in general;
3. The humanistic pyschologists (or the 'third force' in psychology) which is represented by Carl Rogers, Laing, Abraham Maslow, etc. The above writers have emphasised the centrality of the subjective life and experiences of the 'client' and the idea of self-actualisation. The humanistic perspective puts great emphasis on the human potential of each person and his ability for growth and development.

Moreover, such an approach considers that the most crucial points in understanding the individual problem are to see how the 'client' perceives such problem. Thus, the individual's interpretation of his suffering is more important than the professional one (phenomenal self report). (For more details see Hall and Lindzey, 1957.)

4. Finally, the existential view which emphasises the importance of the individual as being himself and autonomous and the centrality of the individual's subjective experience. Moreover, the existentialists believe that the verbal claim "given by the patients themselves regarding the change in their world of experience, their expressions, hallucinations, gestures, and movements can be logically understood in detail" (M. Bleuler in Shershow, 1978, p.13).

Now let us examine in detail the main features of the RFD approach and how such a model views human functioning. This view, as we shall see, has a significant moral bearing on the way mental health professionals define and deal with 'mental illness'.

The purpose of the present approach, therefore, is to establish the following criteria for determining the inefficiency of function in a given situation.

1. There are three major functions which give the significant characteristics of each individual person. These functions are as follows:

(a) physiological function: in this function the behaviour is motivated to satisfy the basic biological needs (e.g. food, water,

safety, survival, and so forth). This function is shared by all people and the normality of this function is crucial in maintining the individual's life. The adequacy of such function can be inferred or understood from the observable inability of the individual's motivated behaviour to satisfy his needs rather than from a hypothetical biological inner dysfunction.

(b) social function: this function is characterised by an effective interaction or communication between a person and his family, friends, work situation, and other environmental variables. The reactive functional disorder (RFD) occurs when the individual's social communicative skill is sufficiently deteriorated as to render the individual unable to meet desirable behaviour standards in his society.

(c) psychological function: each individual has a unique experience and interpretation of events around him. Thus, an individual's behaviour is a continuous reflection of his experience, personality, attitudes, and values. The individual lives in harmony when acting on the basis of his total experience. Moreover, the individual's experience serves to adjust his behaviour to face familial and societal pressures. The effectiveness and acceptability of behaviour depend, thus, on the applicability and relevance of the individual's total personality traits, his unique attitudes, and his personal qualities. Functional disturbance on this level is, thus, a sign of frequent and continuous societal and familial contradictions and misinterpretations which prevent the individual person from defining and expressing his potentialities (see Laing and Esterson, 1970). In other words, such functional

disturbance might be the result of a basic contradiction in the content of understanding or reasoning that is attacked by both the individual himself and others.

2. The individual's psychological suffering and symptomatic behaviour are only prima facie manifestations of the deterioration of the person's essential traits of competency, his sense of responsibility, and his capability for sound choice and judgement (Wear, 1980). It must be emphasised that each individual with reactive functional disorder should be viewed as a genuinely important, fully individual person and prima facie able to control the consequences of his social interpersonal relations in a method which complies with his personal objectives. The concept of reactive functional disorder does not invalidate the purposeful nature of function. The individual total functioning is basically sound and goal oriented. Psychiatrists in this respect must try to be unbiased towards all ethical and subjective components of the disturbed individual. The authority of the psychiatrist to make a decision must be counter-balanced by the individual's right as an autonomous agent to have his unique choice and judgement. A necessary prerequisite for the occurrence of RFD in many psychiatric conditions, is considered to be the total failure of both the psychological and social functions as perceived and experienced by the individual himself.

A failure of the physiological function, or a general deterioration in the physical or biological level could possibly, but not necessarily, be taken as an indication of failure on the psychosocial level. This is because there are certain psychopaths and

severely disturbed individuals who manifest a clear total failure in their psycho-social function due to the fundamental incongruence between their own subjective experience and the established rules and values in their society. Those individuals might not even admit or be fully aware of their total disturbance and their physiological functions might work adequately. Therefore, it seems necessary to accept some limitations when dealing with the RFD approach as applied to certain conditions. It must be stressed here, however, that very few psychiatric cases represent individuals who are totally disturbed or severely psychopathic.

3. The individual's functional disturbance may come under psychiatric attention not because it is stressful or problematic in itself, but because of the nature and content of the cognitive and motivational pattern that both the individual and his basic group attach to the problem. Clinicians and lay people are usually moved not by the manifest function in itself, but by the consequences of such function (whether it is dangerous or threatening to the safety of others), and the suitability of the motivational and cognitive system that framed such function, especially if that system falls outside of their customary experience. Thus, it is crucial to evaluate the inefficiency of the individual's reaction to external stimuli on the basis of the person's own definition of himself and his environment as it is presented to the clinician in charge. The patient's own subjective judgement of the impact of stressful events in his life proved - throughout the research conducted by Byrne in Rey et al (1988) - to have a higher significance of predictive value than did a consensus evaluation of the same events.

In other words, the evaluation process of the individual's disturbed functions must take into account the individual's response as it appears within his total functional behaviour towards others. That is to say, a central element in psycho-social functioning is the individual's motivational and cognitive system which is largely determined by his personal system of values. However, the degree of disturbance in this system is usually decided by psychiatrists in their daily practice on the basis of whether the total coherence and structure of the system is appropriate or inappropriate, reasonable or unreasonable. A detailed account of the above arguments will be presented in the following chapters.

Perhaps the best way to explain how RFD works is to apply it to some of the psychiatric cases discussed earlier. Let us start with Mr. D, who was apparently admitted to the psychiatric hospital because he gave all his money to the poor. Clearly, Mr. D's moral judgement is perfectly rational, if his strong commitment to religious belief is taken into account. His spending behaviour could be viewed as a reflection of altruistic motives which are characterised by self-sacrifice, unselfishness, sympathy and obligation to the poor that may take precedence over his personal wishes. Such behaviour could be the result of childhood training in which such characteristics might have been positively reinforced. It is crucial to bear in mind that people differ widely in the extent to which they display generous, giving behaviour (different people have different experiences and values). Thus, rather than classifying Mr. D's behaviour as abnormal, it is the clinician's task to understand why his 'patient' is functioning in this particular way, and why such altruistic behaviour could have

a negative effect and produce adverse evaluation on the part of the family. If Mr. D failed, for example, to be altruistic due to family pressure, this could have induced in him a partial failure in the psychological function (e.g. feelings of guilt, depression, etc.) - as a consequence of not functioning in a way that reflects his actual personal values and unique experience (psychological function). In addition, the family's pressure on Mr. D's spending behaviour represents an interference with his moral beliefs and an under-estimation of his ability to make his own decisions and express his own judgement.

Now consider a hypothetical situation where Mr. D, after spending his money, felt that he had done something wrong and that he should not have acted in such a foolish way (as his family believed). Eventually, if he really was the very sensitive, intense and somewhat extreme personality that his condition indicated him to be, he might feel depressed, stupid, might refuse to eat or drink, and in the end might even try to commit suicide in order not to repeat his irrational behaviour. Clearly, in this case Mr. D would be viewing his behaviour as negative rather than as positive, altruistic behaviour, befitting a truly religious person. In other words, Mr. D would react to the situation by developing a negative functional reaction to his spending behaviour. He would attach a negative meaning and understanding to the act of spending as a consequence of the negative meaning which was attached by his family to such behaviour. As a result, a general deterioration in the individual's major functions would occur. On the physiological level, Mr. D might have a general disturbance in

the behavioural goals which are considered essential for survival (e.g. eating, etc.). On the psychological level he might suffer from depression and eventually try to commit suicide (as a result of the contradiction between his experience and actions on the one hand, and familial explanation of his behaviour as 'odd' and 'bizarre' on the other hand). In terms of his moral judgement he would attach a negative meaning to the value of helping the poor because he would feel that others view his altruistic behaviour as irresponsible, incompetent and illogical. Consequently, there will be a disturbance in Mr. D's social function, i.e. reduced capacity to keep friends, continuous conflict with societal demands, etc. In clinical psychiatric practice, mental health professionals would tend to view Mr. D's spending behaviour as an indication of "a psychotic condition". The main question which arises here is: what kinds of functional behaviour are regarded by clinicians as "abnormal"? and on what grounds do they base their judgement?

Generally speaking, the decision that a person needs psychiatric intervention is prompted by a suicide threat on the part of the patient, for example, or the patient's presumed unhappiness which is considered to be deviant and as such alarms people into taking action. In reality, the criteria of being dangerous to oneself or not-conforming with the standards of an 'average' person has shifted the emphasis from the contribution of societal and psychological factors to the development of the disturbed function to something else that can be best described as protecting and safeguarding the feelings and wellbeing of 'others' rather than the individual himself. That has led psychiatrists to be less appreciative and less informed

about other functions of the individual patient which are little, or not at all, affected by his psychiatric condition.

Miss N's case which was mentioned earlier in this chapter, is another suitable illustration of the above points. Ms N suffered from an obsessive-compulsive neurosis and admitted herself to the psychiatric hospital under extreme pressure from her relatives and psychiatric friends. Her behaviour was presumably judged on the basis of psychiatric efficiency without any regard to her functional effectiveness as a lecturer, or her functional social activities in general. However, it is difficult to define efficiency of behaviour. Mental health professionals would need to evaluate Ms N's current disturbed level of function in relation to other average or normal functions. Thus, according to the RFD model, Ms N's level of performance in the two major functions, the physiological, and the social one, are of average or borderline standard. The only disturbance occurred on the psychological level and was due, in the opinion of the present writer, to her over-protected upbringing. Her mother was a very controlling and demanding person who had considerably limited her daughter's independence and freedom to construe reality in her own individual way. Ms N, therefore, had very little experience of coping with the everyday problems of living. Additionally, her problem was exaggerated by her family and subsequently by the hospital staff.

If one considers Ms N's total level of functioning, it could be said that this is not sufficiently disturbed to merit psychiatric intervention. Ms N has managed to live a fruitful life in spite of her so-called psychiatric condition. She is an accomplished

lecturer, and manages to conduct her social life in an acceptable way. She has a few close friends, she prays, fasts during Ramadan; she eats and sleeps normally - in other words, she functions adequately in most areas of her life.

Another example would be Mr. B's case which was discussed earlier in this chapter. Mr. B's close friendship with Mr. A was severed due to the relationship being diagnosed as 'homosexual' by the mental health professional in charge of the case. Similar to Ms N, Mr. B admitted himself to the psychiatric hospital due to persistent pressure from his family, and the psychiatrist in charge of the hospital. Mr. B's friendship with Mr. A was, in fact, a perfectly rational goal-directed behaviour, if considered in the context of his family background which had failed to provide him with significant models of identification. Thus Mr. B had been functioning normally on the physiological, social and psychological levels until psychiatry intervened. That is to say, he had been an average student in the university with a few social relationships (social function). Moreover, he had been happy and fulfilled by his friendship with Mr. A and had been motivated to plan for the future (psychological function). He had not suffered any loss of appetite, lack of sleep, disturbance in his memory or intellectual function (physiological function). Mr. B received a psychiatric label not because he was really 'sick' but because he had a concept of friendship which was somewhat different from the concept most 'normal' people are supposed to have in the opinion of the psychiatrist. One of the reasons why mental health professionals have tended to view Mr. B as 'abnormal' could be because it is stated in most textbooks in abnormal psychology or

DSM-III or any psychiatric manual, that over-attached relationships are not within normal acceptable standards. Mr. B's relationship with Mr. A is thus perceived as disturbed and irrational. Such psychiatric diagnoses will eventually create the feeling of moral 'weakness' on the part of the patient and a feeling of incompetency to formulate any forms of relationship in the future. Labelling Mr. B's relationship with Mr. A as 'homosexuality' might eventually create a great confusion in his perception in general towards human relationships as something noble and respectable.

The above analysis illustrates clearly that none of the above cases has shown inconsistency in his motivational and cognitive system. Mr. D's spending behaviour was consistent with general humanitarian ethics that are accepted in most societies. In Kuwait, for example, Mr. D would be considered as a true Muslim and his act would be encouraged. Moreover, his act would represent an honourable and admirable one. In Muslim countries, there is an Islamic law which stresses the importance for every true Muslim to pay a certain percentage from his money (every year) to the poor. Again, Mr. D's case raises questions of the relative nature of the concept of mental illness and the competency of mental health professionals to decide accurately the dividing line between appropriate spending behaviour and irrational or crazy spending.

Now, can we say that Mr. D's response to a command from the Gospel can be judged as a form of delusion? According to Glover in Fields (1987):

> "Where I hold a false belief despite being presented with overwhelming evidence against it, and my doing so cannot be explained in terms of the beliefs common in my group or society, the only explanation that seems to be left is that my reasoning abilities are impaired to an abnormal extent." (p.201)

Fields (1987) disagrees with Glover's account by stating that:

> "For if one considers a particular delusion in isolation from the patient's other beliefs, one may find either that he has no overwhelming evidence against it, or that it seems explainable in terms of a widespread ideology in his society. ... We are able to judge that the patient's belief is a delusion when we take into account some of his other beliefs. We realise that the belief in question does not exist in isolation, but forms part of a set of inter-related beliefs in which the other beliefs of the set are clearly counter-evidential and idiosyncratic." (p.201)

Surely Mr. D's 'first order' (Harry Frankfurt in Fields, 1987) desire to give his money to the poor is a response to a certain 'illogical' command and is not based on false beliefs because there is no "overwhelming evidence against it" (Glover in Fields, 1987, p.201). Mr. D's behaviour, in addition, can easily be explained in terms of certain fundamental notions of Christian society (e.g. charitable and generous behaviour, self-sacrificing act, kindness, mercy, sympathy, understanding, etc.).

If we now discuss Mr. D's spending behaviour in the light of Fields's account, it seems that Mr. D's response to the command from the Gospel (if we believe that such behaviour is considered to be a form of delusion), does not indicate that other beliefs in

his life are coloured by such delusional thoughts. Our previous analysis of Mr. D's total functional ability indicate that there is no evidence that other central aspects of his life showed alarming deterioration. On the contrary, Mr. D's first-order motivation (helping the poor) was coherent and logical when one assumes that such an effective humanitarian desire might be a reflection of a church-going or earlier religious education.

Ms N's 'unrealistic' idea about urinating in her clothes was conceived by her as an irrational form of thought. Thus, Ms N was fully aware that the ideal norms and patterns that must govern the total working of the motivational and cognitive system had been violated by her irrational ideas. She had hoped that such consistency would be achieved in due time. Nevertheless, Ms N was able in many instances to master and to control the persistence of such thoughts (she was an effective lecturer, developed a few social relationships, etc.). That led us to the conclusion that the case manifested certain abilities to regain and re-attain the regularity and coherency in the motivational and cognitive system. In other words, Ms N showed a continuous effort of 'will' to overcome her - in Harry Frankfurt's terms (in Fields, 1987) - first-order motives (obsessive-compulsive behaviour). On many occasions she was fully conscious of her conflicting desires (her first-order desire to respond to such 'irrational' thought and her second-order motives, not to respond). The case history of Ms N shows strong evidence that on many occasions, she manifested a strong determination to act in accordance with her second-order desire, i.e. not to respond to her ritual cleaning habits.

Finally, Mr. B, too, was judged by the psychiatrist in charge on the basis that his friendship with Mr. A was not within the 'clinical' limit of an accepted form of relationship. Mr. B's close relationship with Mr. A is a natural and expected response to satisfy an urgent need for a loving and dear friendship that might counterbalance Mr. B's previous empty life and his need for some sort of social compensation. Surely there is an intelligible awareness from Mr. B to his basic need and in addition there is a certain consistency between his motives or his desire for social life and the importance of such a particular friendship in the reconstruction of his social function.

In conclusion, it has to be stressed again that none of the above three cases chose to be psychiatric patients. Moreover, psychiatric intervention in the above three cases was based on the assumption that their 'symptoms' represent a "hard psycho-pathology" (Wood, 1984, p.35) which was not established through a thorough analysis of the cases.

5. The Reactive Functional Approach and the Problem of Psychiatric Abuse

As previously mentioned, the psychiatric labels that are currently used in the definition and classification of mental disorder such as 'undifferentiated type' or 'residual type', 'disorganised type' of schizophrenia, etc., are liable to misinterpretation and misapplication in actual practice. Moreover, such terms tend to promote many negative, long-lasting personality traits (Rimm, 1977).

The conceptual and moral limitations of many psychiatric terms alongside the absence of both reliable independent diagnostic system and specific pathological causes for most forms of mental illness have led many clinicians in different countries (such as Kuwait, Roumania, Uruguay, the Soviet Union, the United States, etc.) to abuse their profession. Psychiatry provides mental health professionals in these countries with perfect tools to control those people who act against the social system. The psychiatric tools are words. Such terms, when used within the medical framework, lead to a confirmation of irremediable and changeless general traits of unfitness and incompetence. Thus the individual is dealt with as if he had lost his moral and civil status (Wear, 1980).

The question, however, is whether mental health professionals might not be treating individuals who actually have a sufficient capacity for rationality and potential positive qualifications to handle society's responsibilities (Wear, 1980).

In other words, does labelling individuals as mentally ill in current psychiatric practice actually imply the presence of a major defect or impairment in the individual's total ability to function effectively in a given society? Surely terms such as 'delusion', or 'loss of touch with reality' or 'loss of insight' do not give a meaningful and practical account of the concept of mental illness. In fact, these definitional terms suffer from "a complete lack of content" (Gorenstein, 1984) when used as a means to understand mental phenomena. The compulsive Ms N or paranoid

Mr. D or schizophrenic Mr. B may manifest their unacceptable symptoms only with certain limited contexts at certain times, and at certain places, while "much of their 'sensible manifold' may remain objective even when they are hallucinating" (Wear, 1980, p.304). The total functional rating of our cases remains appropriate and within average or borderline standards. In other words, the 'patient's' basic cognitive and motivational abilities might not be defective.

> "A woman who believes that her husband has men in the attic who are trying to influence her by x-rays may be able to remember general information and events from her past life, to speak clearly and connectedly, and to appreciate where she is and whom she is with.
> (Fields, 1987, p.203)

That is not to say that human suffering or mental distress cannot be established as an everyday fact, but what needs to be addressed and examined carefully is the current scientific practice of labelling of human suffering as a form of 'mental illness' (see Redlich, 1981).

"Communicating a large amount of information in a few words" (Robins and Helzer, 1986, p.426), does not justify creating labels or few words to describe the overall patterns of individual functioning. The individual's total functioning is far too complex to understand in terms of one single experience or symptom. If a depressed patient, for example, kills himself, it does not follow that every depressed individual will commit suicide. The current diagnostic criteria in DSM-III are thus "imperfect descriptions of reality" (Robins and Helzer, 1986, p.418). Mr. D's spending behaviour, for example, is perceived by his wife, the police, and the psychiatrist

as irrational or delusional, but that does not make Mr. D's behaviour unintelligible and the others' intelligible simply because the other parties involved could not make sense of it. Not being able to comprehend Mr. D's 'bizarre' behaviour is not a sufficient condition for labelling him as mentally ill or irrational. In fact, many psychiatric symptoms are "only prima facie indications of the diminishment of an individual's capacity" (Wear, 1980, p.307; see Lidz, 1977). Mr. D's wife viewed his behaviour as bizarre or irresponsible and most people would presumably consider Mr. D as a psychiatric case and would certainly take some sort of action to 'protect' him. And yet, if Mr. D failed to manage his personal money wisely, it would be unreasonable to assume that another person, i.e. the psychiatrist, could teach him how to manage his personal affairs. The psychiatrist's basic training is in 'medicine' rather than in moral or ethical issues. Therefore, he is not qualified for making judgements on personal and moral values.

The problem stems from the following: first, the psychiatrist's adherence to the medical model which results in viewing cases such as Mr. D as objectively 'diseased'. Thus diagnosing and curing has nothing to do with the patient's desire or motivation to change. Secondly, the current diagnostic schemes in psychiatry do not take into account or express the uniqueness of an individual case. In actual practice, mental health professionals identify the pat ient's symptoms either by the way such symptoms appear within the clinical interview or as they are reported by their families, and make a decision within the general framework of DSM-III or ICD-9,

etc., as to whether the individual has the right amount of given symptoms to justify the given definition. Moreover, there are certain groups of symptoms that can be categorised under more than one title in psychiatric manuals. This is because mental health manuals lack a definite and accurate definition of psychiatric symptoms or the concept of mental illness in general. Thus a definition of mental illness on the basis of criteria chosen by specific psychiatric schools does not necessarily qualify mental health professionals to deal with problematic issues such as what is 'abnormal' behaviour, what are the feelings of 'psychotic' patients, what is the meaning and purpose of their irrational thoughts, or the problem of predictive validity of the different forms of psychiatric conditions. (Is Mr. D's spending behaviour, for example, deviant or abnormal?) Bearing this argument in mind, it would seem that the methodological and practical limitation of the concept of mental illness would lead mental health professionals to over-emphasise the significance of Mr. D's spending behaviour, for example, as an indication of thought disorder. Therefore, Mr. D's spending behaviour is likely to be viewed as a symptom of schizophrenia for example, since non-schizophrenic individuals do not display such symptoms. It seems, however, that the above problem is related basically, as we have already established, to the difficulty psychiatry has in separating social values and norms from the 'clinical' norms. Homosexuality, for example, as a criterion in the DSM-III was dropped from the manual not because of the introduction of a more accurate and advanced definition of the problem, but because of the shift of norms and attitudes in society towards more liberal ones. The crucial point here is that the medical

professional status of psychiatrists which gives them socially and legally approved authority to impose their values or standards on Mr. D, or Mr. B, or Ms N's or Mr. M's behaviour must be counter-balanced by the rights of those individuals to their unique attitudes and choices built up throughout their life (Back, 1973, see also Abraham Maslow in Davison and Neal, 1986). Thus, it is important to understand and evaluate in detail both the frame and content of the individual patient's behaviour within his social and work group, and the action of the social group upon him. That is to say, professionals must pay attention to the underlying causes of inefficient functional responses and how such functional disturbance influences the individual's total functions. In addition, the significance of meaning of the "disturbed function" to both the individual and his social reference group must be taken into account. Mr. D's spending behaviour and Mr. B's friendship with Mr. A illustrate how the contradictory meaning of the function developed by the individual cases and by others (social group and clinicians), play a crucial role in determining the efficiency or acceptability of the behaviour in question (see Laing and Esterson, 1970). In fact, the understanding and meaning that both the patient and the reference group attach to the situation, and the way the patient interprets his problem determines the ways in which his major functions work and the acceptability or the effectiveness of the individual's total functional response.

Unfortunately, in psychiatric daily practice, the more threatening and severe the behavioural manifestation, the more mental health professionals are likely to ignore or deny the fact that people such as Mr. D, Mr. B, Mr. M and Ms N do not react simply to the objective features of any given situation or problem, but to their own personal experiences, beliefs, subjective interpretation, and motivational system. Generally speaking, people create different forms of new adaptive behaviour and new meanings in their life and are not merely influenced by societal and familiar 'ready-made' norms. Our previous cases showed certain abilities to conduct their lives and to control the outcomes of their social interpersonal encounters in harmony with their personal goals, their unique experience, and the meaning they have chosen for their lives.

The RFD tries to incorporate the above issues and views mental disorder as a temporary reactive functional disorder, that is, a significant disturbance in the individual's major functions which would lead eventually to a significant malfunctioning of the psycho-physio-social response to different life stress. In such cases, the patient would have great difficulty in making the necessary balance between his unique experience and moral beliefs on the one hand, and the behaviourally tolerable standards of a given society on the other hand.

The emphasis on the totality of functional disturbance aims to highlight the fact that if the 'psychotic' patient suffers from a temporary or episodic disturbance in his functional ability

to cope with specific life stresses, it does not follow that his disturbance is related to his whole basic orientation or his total functional effectiveness towards the basic tasks in life that are necessary to maintain his social and humanistic agency. As we noticed earlier in this chapter, Mr. D's spending behaviour is not necessarily irrelevant or irrational or odd, although there are strong pressures on him to conform with the reference group norms or to judge him within the general framework of psychiatric efficiency. Instead, Mr. D's behaviour or Mr. B's friendship with Mr. A could be viewed as meaningful and appropriate behaviour. Consider, for example, the hypothetical case of a woman who experienced a rape, and in consequence developed a general wariness of any kind of future relation with the opposite sex. Obviously, within the psychiatric framework, she suffers from 'a phobic anxiety', although she has a rational and convincing motive to fear men. Thus, it is crucial to evaluate the disturbed function in the context of the total function of the individual and to analyse the level of functional disturbance. Such analysis must be based on a mutual agreement between both the psychiatrist and the patient on the significance of the degree of disturbance in any given functions. (A detailed account of the nature and purpose of the mutual agreement or contractual relationship between psychiatrist and patient will be discussed in the following pages.)

The RFD model emphasises total functional failure as a necessary condition for diagnosing a person as a psychiatric case. Could it be that if only a physiological functional failure occurs in the above case for example, this would be a perfectly sufficient

condition for psychiatric intervention, even though the remaining functions (the social and psychological) work appropriately? Of course, physiological functional failure is a very serious condition which can endanger seriously the life of the individual under discussion. But the question arises here as to whether such a hypothetical case or any case suffering from disturbance in physiological function should be treated as a psychiatric case. It is not difficult to argue that deterioration of the physiological function belongs more properly to the realm of general medicine rather than that of psychiatric provision. If we are to consider physiological functional failure as meriting psychiatric provision, it must be clear that such physiological deterioration is a reflection of a general or total failure of all the remaining functions. The problem with the physiological function as a criterion, as we have already established, is when one considers some forms of psychopathic condition as involving patterns of mental illness (which are very few in reality). In those cases, the psycho-social functions are radically deteriorated, but the physiological function might work perfectly. For that reason, the present writer accepts an obligation to view the criterion of physiological function when applied to the above conditions, as a sufficient rather than a necessary condition for the application of the RFD model.

Bearing our discussion so far in mind, the question which arises is: in what way does the RFD model succeed while other models of mental illness fail?

The RFD model works on the assumption that most individuals with conditions described as 'mental illness' have the ability to accommodate and adapt in one way or another to their suffering.

We do not really question the fact that people might have dehumanising and severe psychiatric conditions, or the fact that current psychiatric diagnostic tools, the definition of mental illness, and psychiatric prediction, although not always 'exact' or precise are nevertheless appropriate procedures for judging the normality of certain cases where the total disturbance of the individual's major function is unquestionable. In other words, one must differentiate between the appropriateness of current psychiatric diagnosis and prediction, and the precision or exactness of diagnosis and prediction. Our main concern, however, is with the moral appropriateness of the current psychiatric descriptions such as "chronic mental defective" or "latent schizophrenic".

The present writer's main proposal is a humanistic and a moral approach that deals with a human being as the master of his body and functions; and recognises his ability to control rather than to be controlled.

The RFD account emphasises the disturbed function as something that could be observed and claimed by the individual himself rather than be presumed or assumed by certain unreliable concepts such as 'vulnerability', 'latency', etc. Adherence to the above principle will surely lead to more protection of the individual from

being subjected to unnecessary confinement or unjustified physical treatment or bizarre diagnoses.

A related central point presented by the RFD is its emphasis on the concept of 'reactiveness' as a crucial element in understanding the nature of the disturbed functions. Once we regard the individual's total functions as a reactive rather than an internal event, mental health professionals will be ready to view the individual's original problems as an interaction between two parties or more (see Laing and Esterson, 1970) rather than the result of unconscious belief, or unspecified and mechanical early S-R relations.

Mr. D's charitable behaviour was presumably viewed by the psychiatrist in charge as a residual deviance (deviation from the acceptable standard of charitable behaviour (Scheff, 1971), or as the result of conflicting unconscious desires (Freud in Hall and Lindzey, 1957), or a consequence of a continuous positive reinforcement that accompanies spending behaviour (Skinner, 1957).

What follows from such different models of interpretation is the way Mr. D would be managed as a result. The above aetiological models put great emphasis on unverified inner concepts which negate any possibilities of free will or self-determination on the part of the case. Mr. D was presumably diagnosed as "a psychotic case" which carried the assumption of inner unknown organic pathology (medical model). Being psychotic means that his spending behaviour is an irresponsible and non-reliable act thus meriting the application

of a 'sick or diseased role'. Needless to say, being psychotic would lead to long-term confinement followed by negative outcomes as a long-term stigmatising effect, different sorts of serious psychiatric medications, etc.

The RFD model would take a different point of view, that is, that Mr. D's spending behaviour is the logical consequence of Mr. D's personal values rather than the outcome of irrational impulse. Certainly, his over-spending behaviour might cause problems to his family. Such over-spending behaviour can best be viewed as a partial temporary disturbance or failure in his psycho-social functioning that results from the way Mr. D has over-reacted to his humanistic values.

The question which arises here is: can a temporary or sudden malfunctioning in Mr. D's psycho-social functioning be considered as a sufficient condition for labelling him as 'schizophrenic' and treating him against his will?

A related example would be Ms N. No one could deny the fact that Ms N was suffering, but there is a crucial difference between saying that, whilst Ms N had a partial and temporary functional failure on the psycho-social level she might possibly regain her past level of functioning, and saying that the case is at the mercy of her unconscious repressed conflicts or unpleasant conditional responses or bad habits.

Ms N, although suffering from an obsessive compulsive behaviour, managed to live, not perhaps attaining perfect living standards, but remaining within tolerable limits. That did not prevent the psychiatrist in charge from recommending her admission to the psychiatric hospital and accepting a pathological concept of her disturbance. This did not help the patient, instead she became worse. The over-emphasis on the necessity of psychiatric admission and medication is the result of the failure of many mental health professionals to communicate effectively with the patient.

Thus, it seems much easier for psychiatrist to adopt a behavioural or medical view of Ms N rather than to adopt a functional approach. That is to say, formulation of a concept of Ms N's problem based on S-R conditioning or unknown physical pathology that will be discovered in due course has resulted in considering Ms N's problem as non-voluntary. In other words, the application of the sick role or medical model was much easier. Consequently, Ms N was viewed as an object without free will. She was the victim of a mechanical S-R continuous process or organic defect lying somewhere in her brain. Thus, medication or behavioural technique was taken to be the most appropriate course of action.

Finally, Mr. B who was diagnosed as having an underlying repressed homosexuality, represents another example of how different models of mental illness can have different perspectives which give rise to the idea that whatever Mr. B suffers, there are always irrational reasons for his suffering or appropriate explanations for such suffering.

Now let us imagine a situation where Mr. B is not willing to admit his suffering to the psychiatrist and instead his family report about his problem. Mr. B would be certainly diagnosed as a psychiatric case. For most models of mental illness, not being able to communicate is a sufficient condition for labelling the individual as a psychiatric case. If Mr. B lacks co-operative skills or if he refuses to provide a verbal claim about his problem, that means that he lacks the necessary insight or he is too disturbed to accept the psychiatric treatment, or that his 'seeming normality' (a Soviet diagnostic term) is present theoretically only but not actually. That is to say that the present models of mental illness have the ability and the flexibility to designate Mr. B as a psychiatric condition whether he is able to communicate or not. Accordingly, all of us are vulnerable to being a 'case' in the future, no matter how closely we now conform to "the normal".

The RFD model instead puts emphasis on the importance of Mr. B's verbal claim and his concept of the problem as something which is tied with his actual experience. Such a claim should be examined in the light of the ability of Mr. B to function in other parts of his life. It is evident from the case history that Mr. B's only problem is the sort of psychiatric interpretation attached to his motivational and cognitive abilities, i.e. homosexual instead of deep friendship. Therefore, there is little point in talking about psychiatric treatment with Mr. B once we agree that his only problem is the psychiatric misinterpretation he received of the acceptable or tolerable limits of interpersonal relationship.

The above discussion shows how the RFD model works on the assumption that a totality of failure in the individual's major functioning with the exception of psychopathic cases, is a necessary condition for any psychiatric intervention. The emphasis here is grounded on the fact that a person is not sufficiently disturbed unless all his major functions are not effectively employed in different aspects of his life. The only possible exception, with regard to certain cases, is the physiological function which is best viewed as sufficient rather than a necessary condition for the application of the RFD model. The reason for this exemption has been argued above.

This analysis of the RFD model as applied in psychiatric practice, highlights the great complexities and singularity of the individual's functions when applied in different spheres of psyco-social life. That is to say, it is very difficult if not impossible to evaluate the disturbed functions 'objectively' due to the inclusion of different variables such as the individual's intentions, his motivational and cognitive abilities, his power of will, etc.

For that reason the RFD model takes a strong position against any attempt to minimise or ignore the right of patients to evaluate their own experience and total functional effectiveness. Such a right could be promoted by adopting (in Szasz's (1987) own words) "a voluntariness stand" or "a contractual psychiatry" where the individual has the right to evaluate his current life and eventually decides whether he needs psychiatric treatment or not. Accordingly, the individual is totally free to accept or refuse the psychiatrist's interpretation of his problem.

What follows from the above is that the individual's verbal claim or his own assessment has to be considered as a valid and sufficient indication of the kinds of factors which have contributed to his present problem.

The problem with much psychiatric research is that findings are presented to the public in a way which create the impression that the individual's problems can be explained by certain mathematical correlations between the individual's functional failure and certain psychological or social factors.

The present writer does not claim that he has sufficient answers for all the above limitations. What the RFD model might contribute in this respect is that when judging whether a particular individual has a total or partial functional failure, the clinician must conduct a systematic and detailed analysis in order to decide whether the individual's major functions central to his ability to pursue his psycho-physio-social activities are sufficiently disturbed or not.

A central means to that purpose as already mentioned is the individual's verbal claim or self-report and the adherence to the principle of "contractual" or "voluntariness stand" in any diagnostic or therapeutic relationship with people described as psychiatric cases. Or, as Mead in Weinstein (1983) proposes in his interactionist model, the importance of the individual's own definition of his 'deviance' and the meaning which is ascribed by others to his deviation.

Clearly the above analysis puts great emphasis on the 'patient's' freedom of choice between different courses of alternative action. Such freedom is a central notion that needs to be promoted in clinical practice. The importance of the 'patient's' self-government and his personal account of his life stems from the following factors: First, there are few psychiatric cases who are, in Wear's (1980) own words, "totally irrational or compulsive. They (those cases) differ in degree, not kind, from the rest of us" (p.299). Secondly, it is difficult, if not impossible, to decide accurately the degree of hallucination or delusion that would have a significant effect on the patient's ability for sound choices in his life. The patient "may suffer from hallucination but learn through therapy to disregard such presentations and lead a competent life" (Ibid., p.307). Thus, symptoms alone which may be present in one context, and disappear in another, cannot be a sufficient criterion for deciding the patient's ability for rational and appropriate conduct in his life. Such symptoms might have a significant effect on the patient's moral agency but only if they are accompanied by a total functional failure. The individual must experience such failure and his inability to function in a proper way. Thirdly, there are a great number of marginal cases (such as Mr. D and Mr. B) where part of the patient's disability is related to a label, i.e. arises from psychiatric diagnosis. Such a label assumes the worst of them and they are treated as 'labelled' rather than individuals with rights and moral values. Fourthly, the patient's symptoms or his total functional limitations cannot be understood if the therapist is not fully aware of or acquainted with all aspects of the patient's personal and social development,

his religion, and his family. That is to say, the patient's total function is 'idiosyncractic' or personal. For that reason such function cannot be governed by general laws or reference, but must refer specifically to a unique individual with his own personal life's events and experience. What we need, as Szasz (1972) argues, is "a semiotical analysis of psychiatric operations" (p.132) in order to help people who suffer certain temporary limitations in their total functions. Finally, it is almost impossible to discover and change the patient's early experience and learning patterns due to the fact that such experience is based on a "massive indiscriminating identification" (Szasz, 1972).

The above mentioned factors clearly imply that even if there is incapacity, or total functional failure, one cannot easily accept the fact that such deterioration "carries a corresponding right to be protected and treated, and thus entails such a duty for others" (Wear, 1980, p.309).

The patient's autonomy and self-determination require "a delicate balance between self-assertion sufficient to safeguard personal autonomy, and self-control sufficient to protect the autonomy of others" (Szasz, 1972, p.2).

Unfortunately, it is very difficult, if not impossible, to reach an acceptable definition or conceptual clarity on the notions of 'patient's autonomy' or 'others' autonomy' or 'self-control'. Whatever our definition is, the psychiatrist is not automatically

entitled to impose a treatment plan on the patient even if he knows what is best for him.

However, no one should be denied the medical expertise of a doctor when genuinely needed, while at the same time, no one would argue that the patient is the only expert on himself, his body, personal thoughts and the nature of his suffering.

Obviously, the kinds of 'patients' we described in the preceding discussion were the ones who are capable of having some sort of 'insight' into their actual suffering. Accordingly, the RFD is more applicable to cases fit for 'psychotherapy'. In other words, cases that are more willing to submit to some form of counselling or educational methods to gain a certain degree of understanding of their disturbed function, or to define their "own conceptions of psycho-social 'illness' and 'health'" (Szasz, 1972, p.255). Szasz (1972) emphasises the above point by arguing that understanding the patient's behaviour and symptoms from his point of view is the basic element that underlines all "rational and autonomous therapy".

In conclusion, what mental health professionals need to accept before any possible attempts to intervene psychiatrically is that they must be aware of the following:

> "... to steep oneself in the events, to approach the phenomena with as few preconceptions as possible, to take a naturalist's observational descriptive approach to those events, and to draw forth those low-level inferences which seem most native to the material itself.
> (Carl Rogers in Hall and Lindzey, 1957, p.527)

6. Conclusion

This chapter has presented a functional approach to the concept of 'mental illness'. Many of the hypotheses discussed here are largely unverified, as they suggest a moral rather than a conceptual account of 'mental illness'. Moreover, the reactive functional disorder (RFD) model highlights the following points:

1. The vulnerability of the concept of 'mental illness' for psychiatric abuse.
2. The importance of the concept of 'totality' in studying functional disturbance and in reducing the problem of psychiatric abuse. The emphasis here is on 'abnormality' as related to specific 'functions' as perceived and experienced by the individual himself and not just to unspecified symptoms.
3. The role of the concept of 'reactiveness' as a crucial factor in evaluating the disturbed function. Thus, instead of viewing the concept of 'mental illness' as something 'residing' inside the individual, the alternative would be to view the above condition as a reaction to environmental and familial conditions that occur outside the individual. The present approach places great emphasis on functional failure as something which occurs within the process of the individual's reaction and confrontation with life's events. Furthermore, closely related to the above point, is the importance of understanding the meaning of the experience which both the individual and his reference group attach to the problem, thus shaping the general frame of reaction of both (Laing and Esterson, 1970). Therefore, it seems necessary to admit, as Tarrier (1979) argues, that the application of the concept of the 'sick role'

in psychiatry would be inappropriate because of the following: (a) the sick role induces in the patient the feeling that he is inactive or submissive and other negative attitudes which discredit his general ability to formulate decisions and to determine his own courses of action; (b) the 'sick role' concept promotes the idea of irresponsibility, through the disease condition on the part of the patient and others; (c) it conceals or masks the fact that the individual's current problem is a mere reflection of conflicting factors occuring in the environment rather than residing within him. In fact, as we noted earlier, people constantly create new actions and behaviours and are not merely influenced by the societal stereotype norms.

4. Although the present approach highlights the inappropriateness of most current conceptual models of 'mental illness' in providing accountable and workable clear procedures for understanding the concept of mental disorder, some concepts and explanations derived from the behaviour model of mental illness, existential psychology, and the humanistic approach in psychology, have been found useful in defining the nature of RFD.
5. Finally, great emphasis is put on promoting the 'patient's' right to choose and to self-determination. Furthermore, it was argued that the individual's autonomy could be fostered through the application of the concepts of voluntariness or contractual psychiatry and a rational or autonomous psychotherapy. The above concepts will be discussed in detail in the following chapters.

CHAPTER FOUR

THOMAS SZASZ AND THE CONCEPT OF MENTAL ILLNESS

THOMAS SZASZ AND THE CONCEPT OF MENTAL ILLNESS

Introduction

Thomas Szasz is one of the most controversial American psychiatrists who argues consistently that mental illness is a 'problem of living' rather than a real medical 'illness'. In other words, the concept of mental illness is a myth and psychiatry is a moral or political rather than a medical discipline. Critics of Szasz such as Moore, Vatz and Weinberg, Roth and many others, argue correctly that Szasz's view on the concept of mental illness and psychiatry in general is based on theoretical and philosophical methods rather than on clinical evidence (e.g. case history, etc.). Nevertheless, Szasz's arguments highlight the conceptual and moral limitation of the concept of mental illness. Central to Szasz's argument is his objection to involuntary hospitalisation and the need to establish psychiatry on the basis of consenting or autonomous psychotherapeutic relationship. In fact, Szasz, as he personally admitted in an interview on BBC2 on Friday, 10.2.1989, is not against psychiatry but against psychiatric coercion and involuntary commitment of people described as 'mentally ill'. Szasz's contribution has been to the analysis of the linguistic and diagnostic methods used by psychiatrists through which they maintain their powerful social status in the society.

Szasz considers psychiatric labels as representing a misinterpretation of the individual's behaviour and his methods of interpretation. For Szasz, the metaphorical interpretation or psychiatric labelling of the individual's problems of living could deprive him

of his freedom and autonomy when his struggle with life's difficulties is viewed by psychiatrists as unintelligible or an indication of underlying pathological agents and therefore meriting psychiatric intervention.

Thus Szasz repudiates the application of the 'disease' or 'medical' model in psychiatry. For him, the medical model requires a well-defined physiological defect in the body to make it legitimate and valid. The application of this model, however, in psychiatry is inappropriate due to the fact that psychiatry as a profession is based on social, psychological and moral norms rather than on well-established biological deviation. Although Szasz does not refute the scientific status of psychiatry, he argues that it cannot "attain professional integrity by imitating medicine or scientific integrity by imitating physics" (1973 , p.68). Such integrity could be attained by the recognition, Szasz maintains, of the fact that problems of behaviour and suffering cannot be explained and understood by the application of mechanical scientific methods because human behaviour requires a special method of explanation, understanding, and interpretation that differs significantly from those methods that are applied in the medical model. Thus, the alternative would be to view such a problem as the result of social, psychological and moral factors. However, as we shall show, this is not an alternative model which Szasz accepts for psychiatry.

This chapter is also concerned with an analysis and discussion of Szasz's general position on the concept of mental illness and

related psychiatric issues. It will be argued that Szasz has made an original contribution towards many problematic issues, for example, psychiatric practices such as institutionalised psychiatry, the vulnerability of the concept of mental illness to abuse, the importance of the right of each psychiatric patient to define himself and his best interest without any kind of professional intervention (autonomy). Some of Thomas Szasz's ideas, however, tend to be rather extreme and need a careful examination. His arguments are based on controversial ideas such as the responsibility of psychiatric patients for their abnormal behaviour and their consequent placement in the category of 'criminals' if their behaviour breaks established laws. Such ideas need to be evaluated critically. Moreover, Szasz invests far too great a confidence in the medical model as if such a model does not suffer from the problems of scientific certainty or the problems of diagnosis, treatment, prognosis and many other questionable issues such as morality, neutrality and ethics. Szasz's position on these issues also needs careful examination. Nevertheless, Szasz's ideas have been very influential in the development of humanistic psychiatry and it is believed that an insight into his theoretical framework will enable us to highlight the limitations of psychiatry in terms of defining and treating mental illness and the significant role of psycho-social factors in the development of human problems.

Thomas Szasz and the Concept of Mental Illness

"Why does the concept of 'mental illness' cause continuing difficulties, both philosophical and practical?" (Szasz in Caplan et al,ed1981, p.459). In many of his books and articles, Szasz suggests

that 'mental illnesses' are not real diseases like medical conditions but are rather behavioural conditions or psycho-social and moral issues. Szasz goes on to argue that the concept of mental illness creates many definitional and explanatory problems. In the following pages, we will discuss the definitional and the explanatory function of 'mental illness' from Szasz's point of view.

1. The concept of mental illness and the definitional problem

"Is there such a thing as mental illness?" (Szasz, 9:384). The keystone of Szasz's theoretical arguments is that mental illness is a theoretical rather than a real concept such as physical illness. That is because "mind is not a body part or bodily organ" (Szasz, 1984 , p.15). For that reason, the concept of mental illness causes continuing difficulties for the mental health professionals. For Szasz, psychiatrists cannot define the concept of mental illness in the same way physicians define physical illness in terms of independent diagnostic indices. Mental illness, as Szasz argues, could not be identified in this way because it does not manifest itself in terms of organic deviation. Szasz's argument begins with drawing some similarities and differences between bodily illness and mental illness (see Szasz, 1987). For Szasz, bodily illness causes pain or suffering, though it may not cause any symptoms ('asymptomatic' - leukemia, hypertension, etc.). Thus, the clinician depends on objective signs that are manifested in X-ray or blood tests in order to decide the presence of bodily disease. Mental illness, however, is identified on the basis of symptoms alone which

express themselves in behaviour. For Szasz "a symptomatic mental illness is an oxymoron . How could a person who does not gamble suffer from pathological gambling? Or a person who does not drink alcohol suffer from alcoholism? Or a person who is never manic suffer from mania?" (Szasz, 1987 , p.93). However, Roth (1976) repudiates Szasz's claims by stating that "Micro-organisms such as the streptococcus or tubercle bacillus cause fatal infections in some individuals and live harmlessly in others. As the latter do not suffer pain or incapacity we do not diagnose disease or regard them as ill" (p.318). Another example would be, an individual who, like many other people with normal physical structure, has a small gland. "As with everyone else, this gland causes him pain, increases his chance of early death, and prevents him from eating a larger number of foods. Despite the fact that this physiological condition (until corrected by surgery) is universal, no one would hesitate to label the state caused by it an illness" (Moore , 1983, p.190). A further example would be a person who suffers from dyspepsia - a complaint which is rarely caused by noticeable organic abnormality. Nevertheless, the condition can be very uncomfortable and sometimes quite painful. Clearly, these examples show that being ill does not necessarily involve a certain pattern of organic signs or norms. The crucial thing, as Moore believed, is the presence of "pain, incapacitation, and the prospect of a hastened death" (Ibid., p.192). For Moore, the problem of Szasz's arguments is that he refuses to accept the dualist argument. Moore maintains that to discuss the concept of mental illness and physical illness as belonging to one category is a logical mistake or "category" mistake. Mental phenomena which

imply rationality, motivation, mental experience and intentions, etc.), cannot be reduced to physical phenomena (see Boorse, 1982). Although Moore's arguments seem very convincing, the examples which he uses to refute Szasz's arguments are not very appropriate. Ronald Pies (1983) argues that bodily disease and mental disease are identified on "what the patient *is* and *does* or *is not* and *cannot do* - not on the finding of a lesion or even a patho-physiological change" (Pies, p.196). The patient *is* in pain or suffering. He *goes* to the physician and *describes* the pain. He might be *unable to talk* or *to move* (Ibid.). However, one cannot deny the fact that judgmental accuracy in general medicine is much higher than in psychiatry.

Although Szasz fails to recognise that even general medicine suffers from problems of scientific uncertainty in relation to diagnosis, treatment and prognosis, (Roth, 1976), he has contributed an important theoretical perspective on the conceptual limitation of the concept of mental illness and the morally negative outcome of psychiatric terminology under the guise of medicine. For Szasz, the 'psychotic' or 'neurotic' individual cannot be understood by using medical terminology. Szasz believes that mental health professionals have gone too far in the medicalisation of their language and that using medical language confers on psychiatrists the power to interpret the individual's problems in a manner which is 'a credit' or 'discredit' to them (Weinberg and Vatz, 1983, p.212). Human suffering, unhappiness and behavioural problems, Szasz argues convincingly, cannot be conceptualised within the medical model because physicians

lack the necessary insight into the complex factors inherent in human suffering (Weinberg in Vatz and Rappaport, and Weinberg, 1983). Behaviour, Szasz maintains, cannot be interpreted as a form of disease. The alternative for Szasz is that human 'problems of living' should be seen within the psychosocial moral framework. Szasz does not deny the existence of human suffering, or the existence of 'abnormal' people. What Szasz objects to is that human suffering and behaviour maladjustment are taken out of the context of the general human condition of which problems of living are an integral part and are firmly placed instead within the narrow confines of medical practice. The problem with this tendency in psychiatry, is that the medical model is ill-equipped to deal with the wider psycho-social and moral implications of human behaviour. What is more, Szasz convincingly argues that the medical model in psychiatry is cloaked in highly technical and exclusive language which invests the mental health professional with 'scientific authority' and endows him with the power to control the life of the individual. Taken to its extreme, this state of affairs can have serious implications for human rights generally, and for the rights of mental patients in particular. Szasz supports his claim of the problematic nature of psychiatric terms by arguing that in actual practice few psychiatrists will hesitate to diagnose a person as 'psychotic' if he shows certain symptoms such as hallucinations or delusions. In fact, the psychiatrist has no choice but to give such diagnosis or designate the patient as having "atypical psychosis" (APA, DSM-III, p.115). The reason for this, Szasz argues, "lies in the prejudgments that words such as 'hallucination' and 'delusion' carry with them" (Szasz, 1987 ,

p.95). In other words, there is a great danger in the power hidden behind the language used by psychiatrists. Thus dissident political attitudes or socially non-conformist behaviour can be interpreted in some cases as mental symptoms. Such symptoms risk being viewed as constituting mental illness rather than as possible indications of illness. Szasz rightly argues that the terms used in psychiatry are often used as if they are a 'description' of the patient's mental functions when actually these terms are no more than 'a prescription' for how mental health authorities must manage the patients.

Let us consider in this context, Mr. D's spending behaviour, discussed in the previous chapter. His behaviour was diagnosed as an indication of mental illness and eventually it was recommended that he be placed in a mental hospital. In fact "once we have translated mental illness from description to prescription, we no longer have to accept or reject the assertion about mental illness" (Szasz, Ibid., p.283). Such manipulation of psychiatric vocabulary, as Szasz puts it, implies a strategic use of mental illness. Such vocabulary, as Szasz argues, could be used to justify, rationalise or obscure moral conflicts as in the cases where the psychiatrists have rationalised and justified the so-called "therapeutic abortion" (see Szasz, 1962). In therapeutic abortion, the practice is based on subjective and unverifiable criteria such as to protect the woman's mental health rather than on well-established medical criteria. The above psychiatric justification was used when abortion was an illegal act in many countries. Nowadays, when abortion has become legal in many countries, "the psychiatric disabilities so common to pregnant women disappeared

just as suddenly as they had appeared two decades earlier" (Szasz, 1987, p.292). Myre Sim in Crown (1970) provides a further support to Szasz's argument when he states that the puerperal psychosis which was considered to be the central justification for therapeutic abortion, is not affected negatively by the continuation or termination of pregnancy. Another example provided by Szasz would be the psychiatric justification of drug addiction. The blame in this example is not directed to the addict but to the drug itself and dealers. The addict, consequently, is an "innocent individual". To provide a full account of how psychiatric vocabulary could be handled in a manner which helps to obscure moral conflicts, consider the following case which was interviewed by the present writer. The case concerns a 24 year old Kuwaiti woman who had been adopted by a Kuwaiti family when she was two years old. The woman in question engaged in an affair with a Kuwaiti man. Her family discovered the affair and had her placed in the psychiatric hospital in Kuwait. The psychiatrists in charge at the hospital were faced with the problem of instilling a sense of morality and responsibility in her personality. This is explained as follows: In Kuwait, pre-marital sex is totally forbidden. This is a concept that is derived from the Islamic culture where a family's honour rests on the chastity of their women. Each girl is responsible not only for her own, but also her family's reputation. Thus the admission of the case to a mental hospital serves to relieve her foster family from any moral conflict. The psychiatrist in charge provided the family with a morally acceptable answer to their problem by shifting the moral blame from the family itself to the 'disease' which affected their daughter's personality. The sexual problem according to the

psychiatrist, is due to personality disorder and not to the actual choice of the individual to behave in a certain way. Thus, their daughter is 'innocent'. On the point of sexual behaviour, Szasz argues in The Therapeutic State that "like any behaviour it may be judged to be good, bad or indifferent; conflicting and confusing such judgements with treatments is unworthy of the human intellect" (Szasz, 1984 , p.351). Szasz goes on to argue that psychiatric diagnosis and treatment for such cases "comes into being not because the alleged patient wants or is willing to submit to it, but because someone other than the 'patient' claims that the 'patient' is 'mentally ill" (Ibid., p.17). Once admitted to a mental hospital, the patient becomes a 'mental case' and, as such, is defined in psychiatric terms which do not take into account the moral and psychosocial factors which usually have a significant bearing on the individual's total functioning. For Szasz, such factors cannot be dealt with by using medical terms. The only possible alternative is that human suffering and the daily struggle with problems be analysed and interpreted within the uniqueness of the psychosocial and moral context of each individual. One wonders whether, for example, if the psychiatrist in charge of Mr. D's case had investigated his psychosocial background more carefully and had become more aware of Mr. D's deep devotion to the true principles of religion, he would then still have diagnosed him as a 'psychotic'. What is more, psychiatric terms such as paranoia, schizophrenia, mania, etc., are highly evaluative in that they usually take behaviour as irrational or in some way incompetent (consider for example, the diagnosis of Mr. D's behaviour and that of the young Kuwaiti woman, discussed earlier). In both cases, the psychiatric

terms used to describe the 'patient's' behaviour serve to devaluate and discredit the inherent rationality and personal will of the people concerned. In fact, for Szasz, the use of such terms reflects a strong belief among mental health professionals that the problem is an indication of clear-cut inner pathological agents and not merely a subjective perception on the part of the person or his family. Szasz's objection is that such claims of suffering do not always necessarily reflect the actual belief and psychosocial structure of the individual. According to him "illness cannot be inferred from only a claim of suffering since we cannot infer suffering from that claim" (Szasz in Weinberg and Vatz, 1983, p.210). For Szasz, psychiatrists cannot claim that they can evaluate objectively concepts such as subjective suffering or rationality or the intentional forces that rest behind the individual behaviour. Moreover, he maintains, even if mental health professionals presumably possessed such technical methods of evaluation or had highly developed communicative skills, it would be difficult to imagine that mental health professionals could effectively alter or reconstruct the individual's sense of responsibility or his power of rationality more effectively than the individual himself. Thus, Mr. D's spending behaviour reflects a strong belief in helping the poor with which his behaviour is in total congruence, while in the case of the young Kuwaiti woman, her behaviour while perhaps unacceptable from the point of view of Kuwaiti society would be understandable to anyone for whom responses to emotion are important.

It is, as Szasz argues, illogical to believe that psychiatrists can be effective in changing people's well-established beliefs unless

the individuals themselves are totally convinced that their attitudes or behaviour are wrong. This is because, according to Szasz, even if they possess highly developed communicative skills, psychiatrists cannot build up their patients' conceptual framework without the cooperation of the patients themselves or their motivation to undergo psychiatric treatment or their acceptance of their role as psychiatric patients. Thus, it appears that the aim of psychiatric intervention in both of the cases referred to above is to "safeguard the sensibilities not of the patient, but of those he upsets. This is a moral and social, not a medical problem" (Szasz, 1973, p.86) and it will "make no sense to select patients on moral or legal grounds, and then study them as if they were medically ill" (Szasz, 1987, p.346).

In support of the above quotation from Szasz, consider the Mental Deficiency Act of 1913 which includes a category of moral defectiveness under which people were committed to mental hospitals for 'immoral' conduct, e.g. sexual relationships and pregnancy outside marriage (Miller and Rose (eds.), 1986). In fact, even today, there are many cases of people treated in psychiatric institutions in countries in the Middle East where illegitimate pregnancy is taken as a serious act of breaking the moral and Islamic code, and an indication of lack of rationality and the ability to weigh up the outcome of a given behaviour. Such cases show clearly the danger of admitting a patient to a psychiatric hospital on moral criteria rather than on the basis of "voluntary psychiatry, or psychiatric relations between consenting adults" (Szasz, 1984, p.25). Accordingly, Szasz put a great emphasis throughout his writings on the dangers of the over-medicalization of psychiatric terms.

As mentioned earlier, such medicalisation, Szasz maintains, will not solve the individual's personal suffering and his behavioural problems. That is because such problems have originally emerged from psycho-social factors rather than well-established medical inner agents (see Vatz and Rappaport and Weinberg, 1983). Unfortunately, Szasz does not provide mental health professionals with an alternative clear conceptual model in psychiatry to deal with patients who suffer from certain mental impairments. This is because he does not set out to do so (see Ibid., 1983). Szasz does not claim that his conception of mental illness is a new model for psychiatric treatment or diagnosis. His approach might best be viewed as a moral and theoretical argument aimed at highlighting the danger of the labels used by psychiatrists to diagnose and commit so-called patients against their best interests.

Szasz questions the current limitations surrounding many psychiatric issues such as the concept of mental illness, psychiatric therapies and diagnosis, psychiatric institutions (hospitals), and how such limitations affect the individual's ability to define himself and his best interest without any interference from others (psychiatrists). Szasz's position on the concept of freedom and autonomy as it relates to psychiatric practice will be discussed later on.

The Diagnostic and Explanatory Function of Mental Illness

Although Szasz's controversial view on mental illness and psychiatric language cannot constitute a new practical alternative for psychiatric treatment and diagnosis, it does raise many crucial questions

regarding the validity and reliability of the explanatory and diagnostic function of the concept of mental illness.

> "While I maintain that mental illness does not exist, I obviously do not imply or mean that the social and psychological occurrences to which this label is attached also do not exist ..... It is the labels we give them that concern me, and, having labelled them, what we do about them." (Szasz, 1973, p.21)

Szasz's basic concern is that the labels which are currently in use in psychiatry imply, as we noted earlier, "Promotive statements in the guise of cognitive assertions" (Ibid., p.50). In reality, the use of terms such as "schizophrenia" imply that the individual's behaviour is irrational and "does not know what he is doing" (Szasz, 1983, p.166). For that reason, Soviet authorities label dissidents as 'schizophrenics' and not as 'homosexuals' or as suffering from personality disorders.

In fact, Szasz does not dispute the fact that mental cases exist in reality, but that does not mean that he accepts the concept of mental illness. As he puts it, a disbelief in the existence of God does not lead one to disbelieve the existence of priests (Szasz, 1987). Thus, Szasz accepts the classificatory act in psychiatry for those 'patients' who have 'real' suffering. His main objection, however, is to the morally negative outcome of the very act of labelling. Such negative consequences could range from a compulsory confinement of the classified individual, which can have dehumanizing effects on the patient, to social stigma, and the certification of incompetency and

irrationality of those who receive the labels. Perhaps the most dangerous consequence of such labelling is that its effects could last permanently. The possible alternative for Szasz is to consider "the context, nature, and purpose of the classificatory act" (Szasz, 1973, p.216). The purpose and nature of diagnosis and classification, Szasz maintains, would make sense only in terms of the availability of an effective treatment (Szasz, 1987). Surely, if a particular psychiatric diagnosis has a negative effect on the patient, as we mention above, and at the same time, does not lead to an effective treatment plan, then it would be not only pointless but positively damaging. In general terms, an effective diagnosis must be followed by an effective plan of management of the disorder, as is usually the case in general medicine. The medical patient, in most cases, knows the kind of treatment he will have and the limits and consequences of such treatment. Moreover, he builds "a concept of his need, and - in accordance with his judgement and his means to command the help he wants - he selects the expert whose service he wishes to enlist" (Szasz, 1973 , p.240). In addition, he can reject his physician's diagnosis. The mental patient, on the contrary, is bound by his psychiatric condition, and by the floating concept of psychiatric causality, to deal with mental health professionals alone and in rather vague and unspecified terms. That is to say, that there are "no clear limits on what the experts are allowed to do, or what in fact they might do ..... the clients are insufficiently protected from such acts they deem to be against their best interest" (Szasz, 1973 , p.240). Szasz continues to argue that in many cases, the individual becomes labelled as a mental patient because someone else claims that he is mentally ill. Such an individual cannot refuse the psychiatric

treatment or the psychiatric diagnosis. For Szasz, the process of classifying or diagnosing a person as mentally ill begins when such an individual occupies the role of mental patient. Once he occupies such a role, "the psychiatrist can - and often does - interpret his behaviour as a manifestation of mental illness" (Szasz, 1987, p.84).

To some extent, it is true that in many cases, where the individual patient is brought to the mental hospital by his family or the police, the psychiatrist finds himself in a difficult position for the following reasons: Firstly, mental health professionals feel a kind of obligation to place patients into diagnostic categories because an unclassified patient is 'unpredictable' and therefore cannot be managed clinically. Secondly, in the eyes of the psychiatrist, the very act of bringing the patient to the mental hospital either by his family or the police, is a clear indication of his 'mental disturbance' and thus merits the label of 'mental illness'. His failure to admit that he is 'ill' or his refusal to sign the treatment's consent form is interpreted as another indication of the presence of mental illness. As many mental health professionals believe, the mental patient is too sick to realise that he is ill. Finally, it may be difficult for the mental health professional to devaluate the perceptions of the family or police who have brought the patient, by refusing to admit him. Additionally, clinicians often feel they need to confirm the social expectation that they have infallible professional expertise and can easily detect the signs and symptoms of mental illness. Perhaps such behaviour can be explained in terms of a defence mechanism on the part of the psychiatrist. On the other hand, the psychiatrist's over-confidence

could be viewed as a reaction to the impreciseness and limitations of his diagnostic powers and explanatory function of the concept of mental illness. Unfortunately, although such limitations do exist, many psychiatrists in their daily practice tend not to give them sufficient consideration. What is more, the inherent weakness of the mental illness model can lead to feelings of insecurity on the part of the psychiatrist when confronted with a case he does not really understand. Szasz presents an interesting illustration to the above problem by stating that "if the patient arrives early for his appointment, he is anxious; if he arrives late, he is hostile; and if he is on time, he is compulsive" (Szasz, 1987, p.85).

Obviously, Szasz's argument leads us to conclude that mental health professionals can interpret any sign of behaviour as an indication of psychological disturbance. The danger implied in the above methods of understanding abnormal behaviour is that psychiatric labels are often used "as if" they refer to something real or factual and not a judgement which can be open to error and misinterpretation. Szasz goes on to argue that the conceptual and problematic nature of the concept of mental illness creates many problems for explaining and understanding abnormal behaviour. A plausible alternative, Szasz maintains, would be to view mental illness as a 'metaphorical' disease. That is to say, mental health problems are in fact problems resulting from psychosocial and moral factors rather than medical ones. Mental illness, for Szasz, as we mention earlier, is a 'problem of living' and human problems of living need not be classified within the general framework of disease. It must be pointed out, however, that Szasz does

not argue against the presence of certain disturbances in the EEG patterns or some physical signs in some 'schizophrenics', for example. The problem, nevertheless, occurs when considering the fact that psychiatrists;

> "..... rarely look for such disturbances (chemical or physical changes) in what we consider normal behaviour. In addition, if we found such physical evidence in a person whose behaviour was conventional, we would not call it mental illness. Furthermore, when a person is 'stricken' with mental illness and we discover certain EEG patterns, we rarely have prior EEG information on that individual. Quite possibly, he had the same EEG patterns when he was considered 'mentally healthy'."
> (Weinberg and Vatz, 1983, p.213)

Throughout many of his publications, Szasz emphasises the idea that the individual occupies the role of mental patient as a result of his violation of an agreed social or moral code in his society rather than a deviation in his EEG patterns. Moreover, as Weinberg and Vatz argue, psychiatrists investigate the chemical disturbances in people who are already diagnosed as mentally ill rather than looking for normal people who might show the same chemical disturbance.

The above attack on the reality of mental illness does not lead Szasz to undermine the effectiveness of psychiatric treatments (e.g. medication-psychotherapy, etc.). For Szasz, the different models of psychiatric treatments are real and may help 'mentally ill' people, "but this proves not that mental diseases are literal maladies, but only that mental treatments can be effective interventions" (Szasz, 1987, p.163). Thus, for example, the effective treatment of sleep

disturbance by sedatives does not in itself prove that the sleep disturbance is in itself a disease - but only that the particular drug has made the individual go to sleep.

In support of the above view, consider the following case concerning a relative of the present writer who was suffering from 'schizophrenia'. Every time he 'relapsed' (or his family thought he had begun to relapse), the police would be called out to take him to the mental hospital. (He refused to admit himself voluntarily, hence the police involvement.) The police would arrest him while he was driving and would justify their action by claiming he had crossed at a red light - then they would take him to the mental hospital.

Each time he was admitted, he received ECT and a course of anti-psychotic drugs for 2-3 weeks. It could be argued that the psychiatric treatment in the mental hospital might have helped the case in question in terms of controlling certain hallucinations and delusions. However, after each discharge, the patient would ask the present writer to explain why the police had admitted him to the hospital when his only mistake had been to cross at the red light. Eventually, he began to display obsessive behaviour, for instance, he would tell a joke to his family, and he would look around and ask them 'will you call the police now?' and carefully watch their expressions to try and perceive what they were thinking about him. He lost his self-confidence and became reluctant to plan ahead even for the simplest action because he was afraid this might give his family the impression that he was beginning to 'hallucinate' again and they would call the police. Now, if we presume this case is suffering from psychotic symptoms and also

presumably believe that involuntary psychiatric treatment will relieve him from the psychotic symptoms, should this lead us to conclude that because the psychiatric treatment results in an effective improvement in his general condition, there is something physically wrong with his brain? Szasz (1987) answers the above question by stating that:

> "We do not infer the presence of medical illness from the fact that after taking a drug, a person, called patient, claims to feel better, or from the fact that someone else claims he acts better."

For Szasz, pathophysiological indication rather than 'other's' claims is the most reliable criteria for deciding the presence of 'disease' or the effectiveness of treatment.

However, there are various other possibilities which Szasz fails to consider in cases such as the one outlined above, namely psychodynamic disruptions, dysfunctions of mental processes, mental causation, etc., all of which are possibilities of mental disease, which could, at some future date, be established by neuro-psychiatric research.

Nevertheless, if the case in question was really a patient suffering from 'mental illness' and if the psychiatric treatment was really effective, he should then have been happier after his treatment, something which obviously was not the case with the patient described above. The analogy with general medicine breaks down here because, even after invasive surgery or other distressing procedures, the general medical patient would probably feel greatly relieved if previous symptoms have been alleviated.

For all of the reasons outlined above Szasz goes to the extreme of rejecting the concept of mental illness altogether and requires that a clear-cut inner pathological lesion be a necessary and a sufficient condition for the presence of 'mental illness'. Such a view has been rejected by some writers who point out the fact that even in general medicine there are problematic issues regarding the diagnosis and treatment of some diseases. Critics of Szasz, however (e.g. Moore and Pies and Schoenfield, Roth, Clare and many others), do not give a full and convincing account of Szasz's controversial views. They assert that the qualification agents for illness are very few and the most important indication for the identification of illness is the patient's verbal report that he is suffering, but omit to answer a very important question, i.e. how a person receives a definition of mental illness in the absence of both lesions and complaints? (Weinberg and Vatz, 1983). As has already been pointed out, in psychiatric practice, there are certain cases in which the psychiatric label is attached by 'significant others' such as relatives, the police, his work colleagues, and other lay community members (as we saw in the case mentioned previously). In fact, this is the most common reason for psychiatric diagnosis. This then, reinforces the notion that mental illness is a third party illness.

Szasz's critics, in addition, are not prepared to answer questions regarding the negative moral consequences of psychiatric definitions and whether identifying human suffering or problems of living is more important than the negative outcome of such identification. Moreover, a definition of mental illness would not establish the

degree of subjective involvement of significant others in the identification of 'mental disturbance'.

The ambiguity and the low degree of objectivity in the process of defining mental patients has led Szasz to question the very nature of 'psychiatric disease':

> "If we are to have a clear and meaningful concept of illness as a class of phenomena (say, Class A), then we must recognise firstly, that there are occurrences which look like illness but which may turn out to be something else (Class B), and secondly, that there are occurrences which may properly belong in the class of counterfeit illness (Class C). All this is logically inherent in classifying certain forms of behaviour as illnesses."
> (1972, p.52)

Clearly, for Szasz psychiatric disorders belong to the class of counterfeit illness. However, Glazer in Roth (1976) has reacted to the above argument by viewing such distinction between a Class A and non-A phenomena as no more than a "dichotomy game" (p.317). Szasz's main problem, Glazer maintains, is that he strictly separates the class of mental illness from the class of physical illness without allowing for the fact that a class of phenomena may belong to both class A and B at the same time which is logically acceptable. Roth (1976) also questions Szasz's strict separation between the two classes of events by stating that:

> "Szasz seems to have no conception of the mental attitude an ordinary medical man takes up when he is first called to see a patient, and the mental processes that then ensue. Probably the very first thing the doctor becomes aware of is a global impression, that the patient is (or perhaps is not) obviously ill. By his history-taking and clinical examination he then confines the fields of inquiry to perhaps one system. Step by step the diagnostic process works its way down to a syndrome, and eventually perhaps, to a disease. Dr. Szasz imagines it quite differently. As he supposes, the doctor first finds physical signs of macroscopic or microscopic cellular changes, proceeds from there to the naming of a disease and finally from the presence of the disease concludes that the patient must be ill. If the signs aren't there, or aren't found, he then says that there is no illness."
> (p.317)

Indeed, even in the medical context, there are certain diseases which could be difficult to classify into clear-cut categories, a situation which could easily lead to errors in judgement. Even the fact that the degree of judgmental accuracy is much lower in psychiatry than in general medicine could be held against Szasz, since he attaches no meaning or consideration to such a fact. Nevertheless, Szasz's basic argument on the conceptual and practical problems which surround the concept of 'mental illness' still stands. As we said before, one of these practical problems is the over-medicalization of human problems of living as if they are real diseases with a clear organic basis. Such "psychiatrization" of life can lead some psychiatrists to ignore the concept of autonomy and the freedom of the individual in their treatment plans. This has prompted Szasz to emphasise the moral and ethical aspects of psychiatric treatment (e.g. the right to define oneself in one's best interest, autonomy, human freedom, etc.).

A careful analysis of Szasz's position on the issue of autonomy and mental illness would reveal that he does not actually claim that the 'mentally ill' individual can always be autonomous or can always be treated as a responsible moral agent. What bothers Szasz is that if we agree to treat patients with a somatic complaint as moral agents and at the same time assume that mental illness has an organic basis, just like physical disease, which will be discovered in due course, then the logical conclusion would be that we ought to treat mental patients with somatic complaints on an equal footing with medical patients. That is to say, we should respect the mental patient's autonomy and his personal claims just as we respect the medical patient's autonomy. In actual psychiatric practice, Szasz continues to argue, "people have been deprived of this right on the ground that their 'true' interest require that they receive 'life-saving psychiatric treatment" (Szasz, 1984 , p.97).

This state of affairs has led Szasz to propose what he calls 'the psychiatric will' - based on the idea of the 'living will' - a written statement prepared by the patient in advance stating that he does not want to be subjected to certain life-prolonging procedures when his physical condition deteriorates. Szasz argues that the idea of the 'living will', can be extrapolated to psychiatry, in the form of the 'psychiatric will' in which the individual has the right to state in advance that he does not wish to be subjected to psychiatric treatment should be become psychotic (see Chodoff and Peeb, 1983). One of Szasz's main arguments is that psychiatric terms are totally inadequate because they tend to ignore the centrality

of psychosocial and moral factors in shaping the individual's total life. So what Szasz claims to be doing is to try to 're-ethicize' ... the language of psychiatry (Szasz, 1973 , p.2). The question which arises here is: Why is Szasz bothering to 're-ethicize' the language of psychiatry when he has already rejected the concept of mental illness and psychiatry generally as a medical discipline?

It would appear that Szasz is in some way confusing issues - the issue of ethics in general and the negative consequences of psychiatric labelling and the issue of the concept of mental illness in itself in terms of its validity and reliability. It seems to the present writer that the possible adverse consequences of psychiatric diagnostic practice cannot in themselves be used logically as a justification to negate the validity of the concept of mental illness or mental suffering or the existence of individuals with different sorts of psycho-social malfunctioning. What is more, maintaining that psychiatric diagnosis must be followed by an effective treatment, Szasz completely ignores the fact that a psychiatric diagnosis, very much like a medical diagnosis, is the first appropriate procedure in the investigation of a human problem - and that again as in general medicine, the problem is not always necessarily curable (see Roth, 1976).

It seems to the present writer that Szasz confuses issues here again - the issue of a diagnosis <u>per se</u> and the issue of the negative consequences of psychiatric diagnosis.

What is more, if mental illness is 'a myth' as Szasz claims, then it is difficult to understand his consistent desire to review psychiatric language, as if he is willing to accept the presence of psychiatry but with certain 'moral' reforms. Indeed, on different occasions, Szasz has emphasised that he is not against psychiatry, but against psychiatric coercion and the restrictions placed on the patient's self-determination (Szasz in After Dark Programme, 1988).

In addition to 're-ethicizing' the language of psychiatry, Szasz proposes that in order to gain a scientific basis, psychiatry must:

> "... recast its theories and practices in a moral and psychosocial framework and idiom. This would emphasise the differences rather than the similarities, between social man and biological man." (Szasz, 1973 , p.167)

The question which follows from the above quotation is, what kind of scientific foundation must psychiatry be based on? Is it the same foundation as that of general medicine? Or does Szasz have in mind special scientific methods used by mental health professionals exclusively? If the practice of psychiatry becomes based purely on "medical-technical methods" this would certainly encourage improvement in its scientific status (i.e. more certainty, higher objectivity, etc.).

Such a development, however, would almost inevitably destroy the centrality of personal and emotional variables in perpetuating

the individual's mental anguish. According to such a model, a dominant mother, or a traumatic accident, or a generally troubled life, etc., will have little bearing on the consideration of this current problem. Szasz's view on recasting psychiatric theories and practices within a moral and psycho-social framework, seems convincing because the field that psychiatry is dealing in is that of relationships, in which emotional and psycho-social factors are implicated. Such factors do not always yield to direct observation and controlled experiment as is the case with the "world of objective facts" (Macmurray, 1939, p.116). That is because human behaviour is too complex a subject, sometimes depending on intangible factors which might be rooted far back in a person's childhood experiences. Moreover, to study psycho-social factors scientifically, it must be clear that this is "only possible so far as we can stand apart from things and observe what is happening without interfering" (Macmurray, 1939, p.86). In the mental health profession in general, it is difficult for the psychiatrist or psychologist to stand apart from what they observe because any given diagnosis or psychotherapeutic plan tends to reflect schools of thought (e.g. Freudian, Rogerian, behaviourist, etc.), religious beliefs, ethical codes, values and attitudes. Thus, as Macmurray (1939) puts it convincingly:

> "... to produce a scientific theory of human behaviour, which will be applicable to all human behaviour without exception, we must assume that all human behaviour is objectively determined, or in other words, that it can be accounted for without reference to the will of the human beings whose behaviour it is."
> (Ibid., p.162)

Clearly, it would be difficult if not an impossible task to introduce a universal scientific theory which would apply to all human behaviour. That is because human behaviour is relative, is often context-specific, is mostly driven by the intentions (motives) and the will of each separate individual. What is more, one must consider the relativistic question of whether it is possible to observe a psychological phenomenon without thereby subtly changing the nature and the characteristics of the phenomenon which is observed.

The above argument leads us to conclude that to establish psychiatry or psychology on a purely humanistic foundation, as Szasz argues (an idea which also appeals to the present writer), will, unfortunately, mean that we will have to accept a low level of objectivity, validity and reliability in psychiatry and psychology as scientific disciplines.

Psychiatry or neurology: a problem of conflicting properties

> "If psychiatrists are especially knowledgeable about the brain and the diseases that affect it ... then they have a legitimate claim to being regarded as medical specialists. But if the domain of psychiatry is the brain and its system therein then the difference between neurology and psychiatry is the same as the difference between a glass half full and a glass half empty. Maintaining such a distinction-without-a-difference is indefensible both scientifically and economically. Given such a case and if academic institutions aspire to be scientific and the law rationally enlightened - educators ought to teach either neurology or psychiatry, but not both; the law ought to recognise either neurology or psychiatry but not both; ..."

and

> "as soon as a disease thought to be mental is proven to be physical it is removed from the domain of psychiatry and placed in that of medicine, to be treated henceforth by internists, neurologists or neurosurgeons ... It is an ironic paradox then, that while definitive proof that mental illnesses are brain diseases would destroy psychiatry's raison d'etre as a medical speciality distinct and separate from neurology, the claim that mental illness is a brain disease has served and continues to serve as the psychiatrist's most effective justification for legitimacy as an independent medical discipline." (Szasz, 1987 , p.70)

The above quotation provokes many controversial questions regarding the legitimacy and limitations of psychiatric practice. Now, if psychiatrists claim that mental illness has an organic basis which can be detected in due course, the questions which arise are: Who is the best qualified to discover the organic basis of psychosis for example? Is the psychiatrist adequately qualified to deal with pathology or with neurology? If, on the other hand, the neurologist and the pathologist were the best qualified to discover the pathology of mental illness, would that mean that the category 'mental illness' should be removed from the domain of psychiatry and placed in another branch of medicine? (Szasz, 1987). Further, if it were the neurologist who established the pathology of mental illness who should then be responsible for the design of the treatment plan? And if mental illness were to be removed from the domain of psychiatry, what would then be the difference between psychiatrists and clinical pathologists?

Such questions are very difficult to answer. Moreover, answers to such questions might lead to conclusions which would be

unacceptable to many mental health professionals. If a researcher were to review the great amount of psychiatric research that is available, he would discover that there is a growing desire on the part of many psychiatrists to understand, explain and treat psychological problems and mental illness in terms of the general frames of the biochemical context. Unfortunately, such research does not tell us whether the neurological or chemical changes in schizophrenia, for example, are causes or effects, or why 'normal' people who have the same chemical changes do not show any bizarre symptoms. Now, if the psychiatrist, or indeed the neurologist, discovers the neurological basis for say, schizophrenia, such a discovery would mean that the patient's personality variables, his subjective needs as well as the environmental influences to which he is subjected are not related significantly to the disorder. A dominant mother, as pointed out previously in this chapter, or emotionally traumatic situations, work pressures, conflicting and contradictory message during childhood, will have no significant bearing on the disorder once it were accepted that the disorder is primarily located in the physical structure of the patient.

Such a shift of the concept of mental illness, if it occurs, from the humanistic approach to the organic one would be fundamental and would require a great deal of careful research, consideration and discussion. If a biological basis to mental illness were to be discovered, there certainly would be fewer problems with objectivity, reliability or validity. But such a development in psychiatry would be at the expense of the totality of individual experience because a number of significant psychological phenomena would be denied validity as crucial determinants of mental illness.

As things stand at the moment however, the psychiatrist treats conditions which are considered to belong to the realm of psycho-social factors, a state of affairs which leads to the problems of low objectivity, low reliability and validity. Because of the complex interaction between the factors and because of constant criticisms directed at psychiatric methods of diagnosis and treatment, psychiatrists have begun to search for ways to solve the above mentioned dilemmas. Sadly, this has meant that psychiatry has increasingly sought to emulate general medicine in its quest for a scientific status. In their endless search for the organic basis of mental illness, psychiatrists have lost sight of the fact that, at the end of the day, they are dealing with human beings - their different personalities, feelings and relationships, all of which are subject to complex environmental pressures. Such psychosocial factors cannot be put under the microscope in order to look for pathological changes. This however, does not mean that the present writer rejects the application of scientific methods to the practice of psychiatry and the mental health professions in general. Rather, the aim here is to draw attention to the dilemma which arises when applying the methods appropriate to general medicine to the study of psychosocial phenomena.

In the final analysis, it seems that mental health professionals will have to accept that they work in a field which is largely governed by psychosocial factors - factors which are difficult to measure and analyse and which interact in extremely complex ways to mold the personal expression of each individual.

Under such circumstances, psychiatry can only be legitimate as a 'helping' profession if it acknowledges its limitations in terms of the understanding and explanation of human experience and in terms of its present methods and investigations (Szasz, 1973a; 1987c).

Such an acknowledgement of the inherent obstacles to 'perfect' scientific understanding of human problems will, hopefully, lead to a greater awareness on the part of the psychiatrist, of the need for thorough and careful consideration of the multi-dimensional nature of psychological disorders and of psychiatrists' practical ability to help resolve human problems. Moreover, such an acknowledgement must inevitably lead the psychiatric profession to the conclusion that there can be few final or ultimate answers in their practice. Rather, it might be more realistic and profitable to think in terms of a primary diagnosis which is liable to change as the individual changes. Finally, it could be argued that, unlike neurology, whose properties are purely medical, psychiatry must acknowledge the subtle relationships between social and interpersonal factors as its very special property (see Szasz, 1987).

Conclusion

> "In asserting that mental illness is a myth, I am not asserting (as some of my critics have claimed) that certain distressing phenomena do not exist. On the contrary, it is belief in the existence of mental illness that prevents us from grasping and accepting the truth about behaviours labelled 'mentally diseased'. In other words, just as disbelief in God does not imply disbelief in his alleged creations, so disbelief in mental illness does not imply disbelief in the myriad phenomena we now label

> 'mental illness'. Personal misery and social unrest, aggression and suffering quite unavoidably exist. But they are not diseases. We categorize them as diseases at great peril to our integrity, responsibility and liberty."
> (Szasz, 1984 , p.15)

Szasz's views on the concept of mental illness are considered by many of his critics as representing no more than a "polemical excursion" from a "bad philosopher" (see Roth, 1976, p.325). However, such critics often misinterpret what Szasz actually argues. Szasz's arguments are based, essentially, on the moral and ethical consequences of psychiatric treatment. He does not deny the existence of different forms of mental sufferings. His basic objection is to the psychiatric coercion, involuntary confinement and inclusion of human suffering, often caused by problems of living, into the categories of mental disease. For him, the 'over-technicalization' of human suffering, has led mental health professionals to lose sight of the contribution of psychosocial factors in the development of individual problems which in turn has undermined the rights of patients for self-definition and for autonomy. The assumption is that a patient is too 'ill' to know what is in his best interest and consequently, he needs, for his own good, to be admitted for involuntary psychiatric treatment which, hopefully, would restore his autonomy. However, Szasz maintains when psychiatric treatment is imposed on the individual, he (the patient) will see the treatment not as serving his own best interests but the benefit of those who had identified him in the first place. Secondly, in Szasz's opinion, the psychiatric patient is considered, due to his illness, to be irrational, illogical and incompetent. In this way, the patient's refusal of psychiatric treatment can be viewed as a

reflection of his irrationality. When the patient is provided with the necessary treatment and begins to feel better, he will, no doubt, appreciate the help he has received. The problem of psychiatric abuse, according to Szasz, lies in the power of psychiatric authorities to force perfectly rational people to have psychiatric treatment for unspecified periods of time on the assumption that they will later be grateful because they would have, ultimately benefited from the treatment. The application of this 'thank-you' theory, Szasz argues, leads to the coercion of mental patients into involuntary hospitalisation and to the underestimation of the patient's capacity to be prima facie rational and capable of supervising his life in an acceptable manner, despite his 'illness'.

Psychiatrists, Szasz maintains, rationalise their actions "on the ground that the recovered patient's gratitude for getting involuntary electroshock or neuroleptics is adequate justification for psychiatric coercion" (Szasz, 1987, pp.315-316). However, it is highly questionable whether the promise psychiatrists hold of eventual 'cure' justifies the deprivation of autonomy, privacy, and personhood which many mental patients go through while in psychiatric care.

Szasz's ideas are difficult to ignore "for he is among the most prominent contributors to medical and psychiatric ethics, discussing issues with a nuance of understanding and sensitivity that is uncommon" (Dyer, 1988, p.77). Szasz's sensitivity is perhaps best reflected in the way he analyses the power of the label 'mental

illness' to dehumanize people by depriving them of their right to define their own lives. Significantly, Szasz believes that it is poor people with little social influence who get stuck with the label because such people are regarded from the start as deficient in some way. The influential psychiatric patient, on the other hand, tends to be regarded by psychiatrists as "a self-governing responsible client - free to decide whether or not to be a patient" (Szasz, 1973, p.86). Thus, Szasz draws our attention to the crucial problem of psychiatric evaluation which is often based on social factors such as economic status, education, etc., instead of on observable symptoms. This 'poor-rich' criterion in psychiatric labelling is frequently evidenced in psychiatric practice in Kuwait where high social status seems to confer special 'rights' on the individual. Thus, high powered, influential individuals are usually visited by the psychiatrist in their homes and if such people ever visit the psychiatric hospital, they would be given a secret file, which will be kept locked in the psychiatrist's desk instead of in the filing cabinet. In addition, the mental problems of such individuals are likely to be viewed by the psychiatrist not as mental illness but as 'exhaustion' or 'anxiety' if diagnosed at all. This sort of practice has led Szasz to view psychiatric diagnosis as largely determined by the social and political status of the individual. This, according to Szasz, has led to the problems of political abuse of psychiatry in countries such as the Soviet Union and to malpractice in the courtroom.

Szasz's view of mental illness is primarily a moral one. He entreats mental health professionals to be "... aware of the extreme

limitation of their knowledge, to undertake a critical reappraisal of their practices, and the principles underlying them. He has made explicit the danger that in certain roles they may have double allegiance, to their patient and to the community" (Roth, 1976, p.325).

Nevertheless, his writings have raised many controversial issues regarding the reality of the concept of mental illness and the moral implications of psychiatric diagnosis and treatment.

CHAPTER FIVE

PSYCHIATRIC PRACTICE IN THE SOVIET UNION:

An analytical study of Soviet psychiatric invalidation of citizens and the role of the RFD model in validating such individuals

Introduction

An important moral and professional goal of medicine is to develop and safeguard the mental and physical health of individuals. Yet the practice of medicine, especially psychiatry, has been abused in many countries, such as the Soviet Union where medical and psychiatric practice is often influenced by the ideology and values of certain political powers rather than by the values that represent the true interests of the individual patient (see Koryagin, 1989). A growing mass of clinical reports and media evidence in recent years shows that medical institutions have been influenced by society's political and moral ideology. Doctors in different countries, especially in the Third World, have collaborated with the political system in examining detainees in order to promote their tolerance to torture or have been giving false certifications to justify the death of dissenters while undergoing torture. Another form of abuse is the inadequacy of proper health care procedures for prisoners. In some extreme cases, prisoners are bled to death and then their blood is used to provide the blood banks with their needs (as is happening in Iraq). (For more details, see Zwi, 1987.) In fact, it would be out of the scope of this chapter to provide a detailed account of all the forms of politically motivated abuse of medicine. In psychiatry, the outcome of such abuse is believed to be more dangerous because of the negative personal, legal, and moral effects of psychiatric diagnosis. Psychiatric abuse invariably has a dehumanizing and devaluating effect on the labelled individual. As a result, misuse of psychiatric 'skills' is likely to result in profound and

long-lasting suffering due to, among other things, the stigmatizing effects of psychiatric labelling.

Today, there is a very clear indication of political abuse in many countries all over the world. Such abuse takes different forms such as the misapplication of psychiatric diagnoses on political dissenters (e.g. as in the Soviet Union, Romania, Bahrain, etc.), emotional and psychological manipulation of prisoners (e.g. Uruguay, South AFrica, Egypt, etc.), and psychological experiments involving drugs (e.g. as in the U.S.A. where some psychologists and psychiatrists are employed by the CIA, etc.). (For more details, see Marks and Greenfield, 1987.) This chapter focuses on the problems of political abuse of psychiatry in the Soviet Union. Such an emphasis is justified by the extent of confirmation and data of such abuse in the Soviet Union and by the existence of a special Soviet diagnostic scheme which gives abuse scientific validity at least from the Soviet point of view. This diagnostic scheme, which is so broad that virtually anyone could be classified under it, provided the main rationale for the abuse of psychiatry in the Soviet Union.

In discussing the problems of political abuse in the Soviet Union, one needs to be clear about two kinds of psychiatric practice. First, poor psychiatric functioning which causes patients to suffer rather than providing them with an effective treatment. Such a poor level of practice is related to factors such as insufficient or inadequate psychiatric training, psychiatrists' emotional problems, and inadequate psychiatric facilities.

Secondly, misuse of the methods used by psychiatrists in relation to the establishment of caseness and management plans for reasons other than medical ones (Bloch, 1984). Throughout this chapter, our main emphasis will be centered on the second kind of psychiatric practice - that is, the misapplication of psychiatric principles of diagnosis and treatment for political reasons rather than the mere reflection of medical incompetence. Our second concern in this chapter is to examine the role of the Reactive Functional Disorder model (RFD) in providing a framework of response to Soviet misuse of psychiatry for political aims. In doing so, the present writer hopes to establish whether the RFD model could provide clinicians with some conceptual answers to Soviet diagnostic practice under which virtually every individual in the world could be classified as mentally ill. Throughout this chapter our main aim will be to certificate the failure of such system to distinguish mental illness. Thus the major contribution to the RFD model will be to establish on the conceptual and empirical level a set of criteria which would help mental health professionals in general to distinguish between the genuinely mentally ill or those who are just labelled mentally ill. A number of case illustrations and evidence will be provided to affirm the misuse of psychiatric diagnosis for political reasons and the role of the RFD model in clarifying the diagnostic unreliability and moral weakness of the Soviet system.

Moreover, as the chapter progresses, we will try to establish whether the RFD model could help to provide mental health professionals with a sense of awareness of the responsibilities of their profession

and to stimulate a debate around the political abuse of psychiatry in general. In other words, our main concern would be to examine the possibility of providing a morally advanced perspective on the methods of defining the individual's total suffering.

The vulnerability of the concept of mental illness and its invalidation of the individual's moral agency

As we already established in the previous chapter, the concept of mental illness is vulnerable to abuse through the application of the concept of 'sick role' which leads to the assumption that the 'patient' is irresponsible and therefore needs involuntary hospitalisation. Moreover, we discussed the different conceptual models of mental illness and how they contribute to psychiatric abuse by viewing the patient as "a passive victim of compulsions, irresistible impulses, or unconscious forces" (Szasz, 1987, p.60). Thus, the patient is "not really himself ..... as someone who engages in behaviour he does not really intend" (Ibid., p.60). Further, it was established that the central criterion of judging a person as mentally ill is whether his behaviour deviates or not from the expected tolerance standards of what society considers to be appropriate limits of conduct (see Scheff, 1971).

Thus, many political, religious and moral beliefs can be viewed as representing no more than a residual deviance or a violation against socially accepted norms of adjustment and hence meriting the class of 'mental illness'.

We shall now discuss the Soviet system of labelling in order to show how the concept of mental illness and psychiatry in general represent a perfect tool for Soviet psychiatrists to control non-conventional thoughts and behaviour.

The Soviet diagnostic system and the concept of mental illness

On the following pages, we will discuss in detail the main characteristics of the diagnostic system used in the Soviet Union. Our main concern will be to answer the following question: Why do Soviet psychiatrists and authorities label their dissenters as 'schizophrenics' rather than 'neurotics' or 'personality-disordered' or consider them disordered at all?

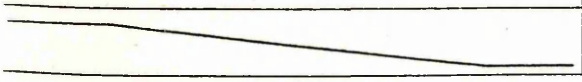
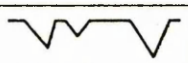
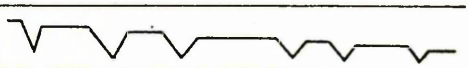
In answering the above question, the present writer hopes to be able to throw some light on how the diagnostic classification 'schizophrenia' is used for political rather than purely clinical reasons (if indeed there are specific clinical manifestations for schizophrenia).

In focussing on political abuse of psychiatry in the Soviet Union, we do not necessarily imply that psychiatric practice in other countries is free from different forms of abuse (as already established in the introduction of this chapter). (For more detailed analysis of the psychiatric political abuse in many countries, see Cohen, 1987.) One justification for choosing to focus on the Soviet Union is that the practice of psychiatry for ideological and subjective

reasons in this country is not only extensive in nature but has, in fact, been reported comprehensively by many psychiatric societies around the world. Furthermore, there is a special school of diagnosis that governs Soviet psychiatric practice. This was established by Andrei V. Snezhnevsky (the founder of the Moscow School of Psychiatry) and well-grounded by the late 1970's, mainly based on thorough research in schizophrenia.

Although the above scheme focuses on a model of schizophrenia, it incorporates very broad criteria of psychopathology which have the ability to accommodate a wide range of mental illnesses. The assumption behind the Soviet system of diagnosis is that schizophrenia has three different forms. A full account of these different forms (Snezhnevsky Course Forms) and their subtypes is presented in the following table:

Three course forms of schizophrenia

	COURSE FORMS						
	Continuous			Periodic	Shift-like		
Life course of the illness							
Subtypes	Sluggish (mild)	Paranoid (moderate)	Malignant (severe)		Mild	Moderate	Severe
Some characteristics	Neurotic; self-consciousness; introspectiveness; obsessive doubts; conflicts with parental and other authorities; 'reformism'	Paranoid; delusions; hallucinations; 'parasitic life style'	Early onset; unremitting; overwhelming	Acute attacks; fluctuations in mood; confusion	Neurotic, with affective colouring; social contentiousness; philosophical concerns; self-absorption	Acute paranoid	Catatonia; delusions; prominent mood changes

(Adapted from Reich, in "Psychiatric Ethics", edited by Bloch and Chodoff (C) 1984, Oxford University Press, p.67.)

The most frequent diagnoses in the Soviet diagnostic system are psychopathy and schizophrenia, and three forms of schizphrenia are recognised as follows:

1) Continuous form: the illness develops and becomes increasingly worse.
2) Recurrent or periodic form: in this form, the patient would suffer from different acute episodes of illness, but after each episode, he would retain his health.
3) The shiftlike form: there are also acute phases, but the patient in general progressively deteriorates after each phase of disease.

Each of these forms of illness varies in degree of severity.

"Sluggish" schizophrenia (a subtype of the continuous form) is the most common label used with political and social deviants. Sluggish schizophrenia may be diagnosed even if the 'patient' does not show any recognised 'psychotic' symptoms. The same patient would not fit the DSM-III or ICD-9 definition of schizophrenia or mental disorder in general. (For more details, see Bloch and Reddaway, 1985.)

In the continuous and shift-like forms, the patient in the mild subtypes would be considered by a Soviet psychiatrist as psychotic. However, if DSM-III were applied, the same patient would undoubtedly be viewed as either neurotic or mentally healthy. This comparison shows that the methods used by Soviet psychiatrists to interpret mild subtype symptoms differs crucially from those methods

applied in other countries, and this is a crucial problem in Soviet diagnostic practice. The problem arises when the individual is considered as having fallen under one of the above mentioned forms, even though he is totally free from any psychotic symptoms. That is because Soviet psychiatrists hold the belief that such an individual has "a life-long, genetically-based condition" (Holland in Reich, 1984, p.69). As Reich (1984) put it:

> "Those Soviet psychiatrists really saw the patients as schizophrenic; or, to put it another way, the symptom created a category, first on paper and then, with training, in the minds of Soviet psychiatrists, which was eventually assumed to represent a real class of patients and which was inevitably filled by real persons." (p.71)

Another dangerous feature of the Soviet diagnostic criteria is the "seeming normality" criterion as it is called by the Soviet authorities. According to "seeming normality", a definition of schizophrenia doesn't necessarily imply the presence of "first rank symptoms" such as delusions, hallucinations, thought disorders, etc. Instead, such symptoms could - from the Soviet psychiatrist's point of view - exist theoretically in a way that does not cause a change in the patient's personality noticeable to others. This 'seeming normality' criterion - which in reality represents no more than a psychiatric excuse - appears to have the power and flexibility to include or to categorize virtually everybody under its umbrella. What motivates the Soviet clinician to use this criterion, even though the abnormality of the 'case' does not manifest itself now, is that he (the psychiatrist) believes that the pathological indication of

the potential patient will be discovered in due course in the future. Thus, the 'seeming normality' criterion seems to have the power of designating and interpreting any sort of behaviour as a sign of 'mental illness', even though there are no symptoms of abnormality, since for Soviet psychiatrists symptoms of 'mental illness' can exist theoretically but not clinically in patients (Professor Lunts in Bloch, 1984). As a result, the application of this criterion indicates its total failure to distinguish abnormality at all or to tell the difference between normal people and abnormal ones. The dividing line between the 'normal' and 'abnormal' individuals is absent and hence meaningless.

Besides 'seeming normality', there are other vague and very broad criteria which have been established in order to house and fit different sectors of people who are considered to be 'inconvenient' for the State (e.g. advocates of human rights, religious believers, persons who try to leave the Soviet Union, etc.) (Koryagin, 1984). Examples of selected criteria which are mentioned in the diagnostic reports of the 'rejected' citizens are: "delusional reformism" or "paranoid delusion of reforming society or of reorganizing the State or of revising Marxism-Leninism", "over-estimation of the personality", "poor-adaptation to Society" (Bloch, pp.335-336, 1984), "uncritical attitude towards his abnormal conditions", "opinions having a moralizing character", etc. (Bloch and Reddaway, 1985, p.147; see also Merskey and Shafran, 1986).

Now, why do Soviet authorities use the above criteria or in general the concept of 'schizophrenia' as a means of controlling their dissenters? A related question would be, why do Soviet authorities employ "psychiatry" as a whole to perform the job of manipulating and supervising 'ill-fitted' and 'unsuitable' individuals?

Thomas J. Scheff (1971) provides a convincing argument concerning the above questions. For him "schizophrenia ... is a broad gloss, it involves, in no very clear relationship, ideas such as "inappropriateness of effect", "impoverishment of thought", "inability to be involved in a meaningful human relationship", "bizarre behavior" (e.g. delusions and hallucinations), "disorder of speech and communication", and "withdrawal"." (p.312)

Scheff goes on to argue that because of the broadness and vagueness of the above symptoms and because of the uncertainties of the definition of schizophrenia, schizophrenia may be used as a 'residual' term which might be applied, without serious thought, to those "residual rule breakers" whose deviant role is difficult to conceptualize in terms of specific definition. In fact, when defining a person as schizophrenic, such a definition in itself obscures rather than clarifies the reason why the person is called schizophrenic, or the question of whether he really caused suffering to others or the social authority responsible for defining him as mentally ill. That is because, as already discussed in the previous chapters, the term schizophrenic as a diagnostic label per se does not provide specific answers to questions such as how the 'disturbance' affects

a person's total functioning or whether he is able to manage, in spite of his suffering, his everyday affairs. Such labels do not describe the 'patient's' subjective experience or the content of his thought or disturbance.

The above arguments lead us to conclude that in any attempt to define abnormal mental functioning, clinicians must not base their assumptions or diagnosis on limited aspects of acts or hallucination but should take into consideration the total functioning of the individual. Kanfer and Saslow (1973) illustrate the above point very well by stating that:

> "The observation that a patient has hallucinated on occasions may be of importance only if it has bearing on his present problem. If looked upon in isolation, a report about hallucinations may be misleading, resulting in emphasis on classification rather than treatment." (p.334)

The above quotation suggests that a psychiatric examination must include a detailed description and evaluation of the patient's behaviour in relation to the various environmental factors. Moreover, the investigation must emphasize the importance of his present as well as his past experience and how such experience has a significant bearing on his total functions. Furthermore, the psychiatrist must be aware of the actual evaluative process that has led him to establish his view that the individual is mentally ill. That is to say, a central part in any psychiatric evaluation is to find out whether mental suffering is based on the individual's personal claim of distress

or simply on definitions by 'others' (e.g. family member, his colleauges, the police, the authorities, etc.) (Mechanic, 1967).

What actually happens in reality is that once a person is diagnosed as 'psychotic' this would carry with it a long-term implication even after discharge from the hospital. At the end of the day the 'patient' is in remission or, in other words, relapses are the expected outcomes of his 'disease'.

Another possible aim in the application of the concept of schizophrenia for political reasons is that once the psychiatrist designates a person as schizophrenic, there is no point in conducting a formal trial. In this respect, trials become a mere conventional procedure without any real chance for the 'schizophrenic' to defend himself because he is considered too sick to communicate his thoughts to others. In other words, his 'word-salads' and 'illogical thoughts' prevent him from being a 'full' rational agent.

Obviously, the concept of schizophrenia provides the Soviet authorities with a practical and legally justified tool for the control of political dissidents (see Koryagin, 1989). For that reason, psychiatry in the Soviet Union has been greeted by the authorities as a legitimate and proper enterprise for dealing with society's 'outsiders' (Ibid., 1989). That is because psychiatry has the ability to "legitimize and define the institution ..... in which only mentally sick individuals are confined. Psychiatrists often assert that there are no normal people in mental hospital. Moreover, the public likes to be reassured

that only the sick are railroaded into the hospital" (Szasz, 1973, p.211). Another reason for selecting psychiatry to do the job, in Szaszian terms, of 'warehousing' political dissenters is the implicit international certification of psychiatry as a legitimate enterprise to diagnose and treat misfits - malfunctioning or, in other words, political misbehaviour as a sign of mental illness.

In fact, when examining the current diagnostic system used in psychiatry, one would soon notice that a central criterion of mental health on which the individual 'patient' is considered to be mentally healthy is 'social adequacy' or 'social adjustment' to the social norms or 'accurate reality testing' (Lazarus, 1975) or competency.

Consider, for example, the WHO definition of social psychiatry (a branch of psychiatry) which emphasizes "fitting the individual for a satisfactory and useful life in terms of his own social environment" (WHO definition of social psychiatry in Schwab and Schwab, 1978, p.23).

Furthermore, social psychiatry's main emphasis is to supply the 'patient' with a set of well-defined norms which are "favourable to the maintenance of social adequacy" (Ibid., p.23).

Obviously, the current view of mental health professionals towards the individual who deviates from what society considers to be 'social fitness' is to consider him as abnormal. A possible

consequence of the above attitude is the certification of new criteria in mental illness, such as "political" criteria. That is to say that the concept of mental illness throughout psychiatry in general, receives "legitimacy" for its use in dealing with political misfits by defining certain activities as appropriate or inappropriate in terms of the standard political norms of a given society (Koryagin, 1989).

Two questions which follow from the WHO definition are: How does social psychiatry decide when an individual's behaviour does not completely or sufficiently fit with the society's norms?, and How much fitness and sound thinking does an individual need to be considered as mentally healthy? Moreover, one needs to know whether mental health professionals as a result have a moral and professional obligation to "... teach people the principles of mental hygiene, methods of sound thinking about themselves, and ways of coping with reality"? (Ellis, 1967, p.441).

In fact, the concept of fitness is much more tied to the view that the individual's personal attitudes and his subjective experience are considered to be not within the real context of society. Thus, the person is "not OK" because he lives in a context which society believes to be odd or bizarre in the circumstances.

Thus, the inclusion of socio-cultural factors in the psychiatric 'clinical' decision must not be overlooked. Fairbairn and Fairbairn (1987) have discussed the concept of fitness or adjustment

and have stated that psychiatric practice is:

> "... inherently repressive since it serves to adjust people to society rather than adjusting society to people." (p.108)

The above quotation is relevant when discussing the situation in the Soviet Union. "Soviet authorities impose their own "beliefs" about psychopathology on an entire population by making the political system itself the agent of prevention and therapy" (Szasz, 1981, p.29).

Reactive Functional Disorder Model and the nature of Soviet psychiatric abuse

Throughout the following pages and with the support of case illustrations, our concern will be with the following issues: First, selected case histories of Soviet political dissenters show that what Soviet psychiatrists are dealing with are perfectly normal people rather than what they claim to be "schizophrenics" (Koryagin, 1989). A careful analysis is needed to examine the normality of such individuals. Secondly, the use of a broad rather imprecise diagnostic scheme and the combination of such a scheme with the medical model has caused many Soviet psychiatrists to view each individual 'patient' with schizophrenic disorders as basically suffering from a genetic defect which carries life-long irreversible effects. Even if the individual does not display any sort of psychiatric symptoms, the Soviet psychiatrists are perfectly capable of establishing that the person is genuinely 'schizophrenic' by the application of the so-called 'seeming normality' 'excuse' which was discussed earlier. The validity of such a scheme

will be examined by using case illustrations. Finally, the use of some terms in the Soviet diagnostic system such as, "overestimation of the personality", "poor adaptation", or "delusion of reformism" suggests that a person is mentally healthy if he fits himself to the conventions and norms of his society. Thus some Soviet psychiatrists adopt certain 'psychiatric' principles in their daily practice that largely reflect the political system in their country in which their psychiatric medical training is basically oriented towards changing an individual's "maladaptive behavior" or his reforming delusions, etc., in order to re-adjust the individual within the society's stereotype or ideal methods of functioning.

The process of 'reforming' individual behaviour usually takes place in an Ordinary Psychiatric Hospital (OPH, for short) or in a Special Psychiatric Hospital (SPH, for short). Once in a mental hospital, it is very difficult for the dissenter to convince hospital staff that he is actually and not only "seeming" normal. As a result, the 'patient' receives a long-term hospitalisation which is characterised by continuous psychiatric medication, alongside cruel and careless management (Holder, 1977; Koryagin, 1989). In fact, Soviet procedures in the diagnosis and treatment of political dissenters serve well to illustrate the empirical applicability to the RFD model. It must be clear that our main analysis of the political abuse of psychiatry in the Soviet Union is basically applied to those psychiatrists who actually or to some extent believe in dissent behaviour as a sign of disease, and to claims that their methods of identifying such 'disease' are reliable tools. The present writer is not concerned

with the practice of some Soviet psychiatrists (core psychiatrists) who are deliberately misdiagnosing dissenters for specific ideological beliefs. (See, Bloch and Reddaway, 1985.)

Our concern is basically oriented towards the explanatory function of the RFD as a plausible alternative explanation of political dissent in the Soviet Union, an explanation which the present writer hopes would be relatively less open to abuse. In addition to other benefits of RFD, it can also tackle the problem of Soviet psychiatric abuse while remaining invulnerable to the kinds of abuse we see in the West. To illustrate the applicability of the RFD model as a possible alternative to tackling the problem of political abuse of psychiatric service in the Soviet Union it would be useful to discuss in detail the following case (cited in Wing, 1978, pp.180-185).

The case is a Leonid Plyushch who was born in 1939 and graduated as an engineer mathematician. He designed a mathematical model of the biological system regulating blood sugar. His involvement in political activities against his country began in the form of writing different letters to different political bodies such as U.N. Commission on Human Rights. Plyushch's main concern was the democratisation of his country, the improvement of political trials and the rights of political dissenters. None of his colleagues considered him as abnormal. Instead, they all regarded him as a creative and responsible worker. His political activities caused him to be dismissed from his work.

After that, he became a founder of the Moscow group for the defence of human rights. Eventually, he was arrested in 1972 for the charge of "anti-Soviet agitation and propaganda". Two Soviet psychiatrists diagnosed him as suffering from "sluggish schizophrenia" from an early age. In 1973, he was sent to a SPH because, in the view of Soviet authorities, his political behaviour represented an "exteme social danger". He was put under anti-psychotic medication which caused deterioration of his intellectual-scientific interests and disturbance of memory, emotion and political interest.

Wing summarised a meeting at the Serbsky Institute in October 1973 at which Plyushch's case was discussed from the Soviet psychiatric point of view:

> "From the age of 15, Plyushch was interested in politics and philosophy and decided to fight against the remains of imperialism in this country. He trained himself by 'training his will, fighting with his softness and ambition'. Aged 23, he graduated as a mathematician.
>
> He decided, while studying, to reconstruct the Communist Party and reorganize the Komsomol. He thought he had outstanding ability. He had lots of new ideas about clothes and music, and was also preoccupied with thoughts about hypnosis. He believed that people could perceive thoughts through breathing. He wrote many manuscripts. He over-estimated himself and thought he had solved problems of great importance for humanity. He sought to have followers, to be called 'Plyushchists'. He complained: 'The head is pushed from its axis - I am becoming mental'.
>
> After graduation, he became an engineer. His interests were in philosophy, psychology, telepathy, biology, and later he also became interested in the arts, literature, and the treatment of stammering.

> He was fussy and suspicious, and passive and indifferent at work. He lost his office pass and was reprimanded. He complained that he was deprived of his human rights and said the government wanted to kill people. His aim was to restore Soviet power. His wife thought him normal but his mother thought him strange; he did not look after his children, his appearance or his clothes.
>
> After his arrest, he was examined by a psychiatric commission on 14 July 1972. He was not anxious over the arrest, thought that there would be radical changes in the country which would prove his views on the world and his policies correct. He said he wished to accelerate the coming of democracy in this country by protesting, for the sake of communism.
>
> On 7 September 1972 he had a further psychiatric examination. He did not try to establish his rightness. He did not regret that he was arrested and was more interested in the problem of integral psychology. His attitude to the future was indifferent. He showed no concern about his family. The conclusion of the commission was that he was suffering from schizophrenia, that he was not responsible for his actions and that he needed treatment in a general psychiatric hospital."

The above case shows clearly that the psychiatric hospitalisation and diagnosis of Plyushch is not linked with his past and present effective functioning as a brilliant engineer-mathematician. That is to say, the psychiatric definition of the above case is based on factors and variables that are completely separate from the individual's total psycho-social functioning. The psychiatrist in charge of Mr. Plyushch's case had set out to discover 'diseased' rather than healthy features in the case. As a result, the emphasis of the 'mental state exam' was directed towards finding specific marginal aspects of his life to support the presence of illness, i.e. the case history put great emphasis, for example, on Plyushch's interest in philosophy and psychiatry (which implies vulnerability to 'delusions'), rather than on his positive contribution to engineering for instance.

Plyushch's political activities were presumably considered by the Soviet psychiatrists as expressing grandiose delusions or 'philosophical intoxication' or "reformist delusional ideas" (see Mersky and Shafran, 1986), diagnosis obviously based on a subjective unverified concept of abnormality. Such a view of abnormality is not related to the actual suffering of the individual or his actual level of functioning. This is because the definition of 'mental illness' is "left largely to the user and is dependent upon the norms of adjustment that he employs. Usually, the use of the phrase 'mental illness' effectively masks the actual norms being applied" (Livermore, 1968, p.80). In order to legitimize such non-psychiatric norms being applied on Russia's political dissenters, Soviet psychiatrists rationalise their decision by providing a medical psychiatric reason for it (for more details on the role of psychiatric rationale in justifying many non-medical norms, see Goffman, 1961) or applying the concept of 'sick role' in general.

In fact, the 'sick role' which derives from the medical model gives Soviet psychiatrists an approved authority to manipulate political dissenters under the guise of providing them with psychiatric treatment. Moreover, the sick role model justifies their intervention by discrediting the 'patient's' objections to psychiatric confinement and compulsory treatment. Psychiatrists' medical justification is that their patients are not fully aware that they are really ill, irresponsible, and in need of 'psychiatric specialized help' to restore their autonomy and their sense of responsibility. For such psychiatric pratitioners, the patient has a terminal and totally destructive

disease which is far beyond his abilities to avoid and for which he requires long term psychiatric treatment to reconstruct the defective abilities.

In addition, as we mentioned previously, there is a strong tendency among Soviet psychiatrists to explain the individual's 'social dangerousness' or 'delusional reformism' for example, as resulting from predetermined unspecified physiological factors rather than on functional grounds. Such a view gives little idea of how the patient who suffers from the above hallucinations, for example, in specific life situations, may well be able to function positively in other spheres which are essential for the fulfilment of basic needs. The above list of symptoms might represent a first-rank indication of schizophrenia, for example, only if they contribute negatively to the individual's psycho-physio-social functioning. If investigated as symptoms separate from the total working of the individual personality, without providing any account of the patient's general ability to function in other areas of his life, such 'diagnostic' criteria would be meaningless and could result in sweeping the patient onto a "downward slide" which make him "unable to stop and climb back up again" (Szasz, 1987, p.43). And, as Szasz convincingly shows, once the individual occupies the role of mental patient, the process of "downward slide" would begin to work effectively.

A careful analysis of Plyushch's case suggests that the psychiatrist in charge has assumed that the patient's "anti-Soviet agitation and propaganda" and his "extreme social dangerousness" along-

side his over-estimation of his personality, reflects a hidden internal cause rather than external observable events (see, Merskey and Shafran, 1986). As a result, even if Mr. Plyushch shows a significant improvement in his total functioning, it would probably be interpreted as temporary and likely to be followed by a relapse because the patient is viewed by the professionals as vulnerable and weak with a relatively permanent diagnosis regardless of later functioning ("residual deviance") (Scheff, 1971). Thus, once the patient is diagnosed as 'schizophrenic', he is always considered schizophrenic thereafter, even if he returns to a normal state, as in the case of the 'periodic form' diagnosis.

Such emphasis on the inner explanation or the inner etiology of deviance leads to great difficulties in making the necessary observations of the manifestations of the illness. This is because inner explanations are vague and unspecified and hence difficult to verify or to control variables within an objective observation. Inner etiology might be the unresolved conflicts in the unconscious or a genetic defect that it is believed would be discovered in the near future. It seems that using such a system of interpretation of inner causes has led many clinicians to presuppose different kinds of unverified causal explanations on the basis that such inner causes, although not actually present, are believed to be theoretically present. That makes the psychiatric definition of any individual an irreversible act as no independent indices have yet been established in psychiatric screening methods.

Plyushch was diagnosed as having "sluggish" schizophrenia which presumes a long psychotic process from an early age. The presence of psychotic symptoms in this type is not a necessary condition for labelling someone as mentally ill. That is to say, the psychiatrist in charge worked on the assumption that there is something wrong with the individual that has its origin somewhere in the body. Thus, the notion that he acts 'as if' he were insane turned out to be the notion that he is 'really' insane. The above hypothesis is supported by a 'weak' hypothetical explanation rather than 'hard' psychopathological symptoms. In this respect, it seems very important to remember that Robert Spitzer himself (the physician in charge of the developing of DSM-III) accepts the possibility that a person is mentally ill without the presence of 'psychotic symptoms'. In other words, it is enough to be a potential case or vulnerable to schizophrenia. The concept of constitutional predisposition or vulnerability implies the notion of an inherent genetic weakness such that under certain circumstances, the individual will be more vulnerable to the disease class 'schizophrenia' (Zubin, Spring, 1977; and Kety, 1971).

Now consider the following case illustration of Mr. O, 46 years old, ex-mental patient. The case was interviewed by the present writer in 1980. Mr. O's family had admitted him to Psychiatric Hospital when he manifested certain philosophical and religious ideas such as: Marxism is the true faith because such ideology encourages people to work more effectively than Islam. That is to say, his family and his psychiatrist were pre-conditioned to assume that such "philosophical intoxication" would be followed by a possible relapse,

even though his philosophical thoughts were sound and reflected highly intelligible ideas. It must be made clear here that the criterion which was used to admit Mr. O was his vulnerability to relapse rather than an actual or real objective deterioration in his total functioning. As Laing in Siegler et al (1972) put it, the problem occurs in psychiatric practice when persons such as our case are labelled as 'schizophrenic', for example, on the basis of "attaching a hypothetical disease of undiscovered pathology" (Laing in Siegler et al, 1972, p.104). What happens in actual psychiatric practice is that most mental health professionals tend to give "undue prominence to deviances which may not have the connotation of illness when seen in the perspective of the individual's current life pattern ..." (Coleman, 1967, p.163).

When examining the current psychiatric situation in the Soviet Union, we will discover that many Soviet psychiatrists deny or ignore the importance of providing the patient's diagnostic sheet with information on how 'delusional reformism', for example, is relevant to the efficacy of his total performance (Bloch, 1984; Bloch and Reddaway, 1977; Wing, 1978). Instead, their main concern is to maintain, through psychiatric medication, conventional thought which meets social norms.

The psychiatric methods of interference in the individual's subjective thoughts and in his rights to make unique choices in life are viewed by Soviet psychiatrists as a humane 'treatment' of mentally diseased individuals. By holding on to such a belief and by practising

in hospital settings, such psychiatrists probably succeed in reducing their feelings of guilt arising from violating humanitarian principles and the constitutional rights of people with so-called 'mental illness'. In fact, even the "right to treatment", Szasz (1984) argued, has become "a formidable new weapon in the psychiatrist's perennial struggle to oppress and control the mental patient" (p.96).

The vulnerability of the concept of 'mental illness' and the subjective nature of psychiatric 'symptoms', as we noted earlier, have played a central role in the function of Soviet psychiatry as a means of control of the individual's thoughts and behaviours. A possible alternative would be viewing "mental disorder" as a Reactive Functional Disorder. In other words, the RFD is an alternative to the medical model.

The RFD model shares with some psychological theories (e.g. behaviourist, Gestalt, existentialist, etc.) and with researchers such as Szasz, Laing, Scheff, Leiffer, Skinner, Rogers, etc., the assumption that symptoms in themselves have no significant value. What is important is the context and nature of the individual's major functions as perceived and experienced by the individual himself (with disclaimers for the seriously disturbed who do not or cannot acknowledge their own illness). The central aim in studying symptoms is to consider how such symptoms are relevant to the patient's present problem and his total life pattern. Mr. O's occasional mild "philosophical intoxication", presumably representing a form of paranoid delusion, might interfere little or not at all with his original

job as a successful merchant. However, the very existence of such philosophical ideas might lead many psychiatrists to form a diagnosis of schizophrenia, for example. (See, Kanfer and Saslow, 1973.) That is to say that when judging the presence or absence of the phenomena described as 'mental illness', the clinician must not restrict himself to a single act or thoughts but to the total functioning of the individual.

In this context, it is important to consider the motivation of the function, the relative nature of the function, the development of the function, and the context in which the function occurs. As Coleman (1967) points out, the "... symptoms are considered to be pathological manifestation regardless of the context in which they appear" (p.163). Moreover, the analysis of how the discrepancies occur between the patient's unique life pattern and the societal pattern of responses is another significant sphere of understanding the degree or level of disturbance in the individual's actual functioning.

The problem occurs when Soviet psychiatrists reply that it is not the reformist behaviour in itself which is troubling, but rather its occurrence in the 'context' of Soviet society, where it is meaningless, irrational and dangerous. Pushing the arguments further on, let us imagine a hypothetical situation where Mr. Plyushch's "philosophical intoxication" has resulted in a total rejection by him of all societal sections (e.g. his family, work, friends, official authorities, etc.). Homosexuals were once rejected by all members

of their society, but nowadays have become a sexual 'preference' rather than a sexual 'deviation'. A woman who delivered an illegitimate child was once seen in Britain as suffering from a 'moral defect' and was rejected by her society and involuntarily hospitalised. The same argument is applicable in the case of masturbation.

The crucial question which arises in this respect is: do the contexts in which the above cases and our present case, Mr. Plyushch find themselves have a crucial bearing on the acceptance or rejection of their behaviour?

In fact, the RFD model emphasises the centrality of the individual's past and present functioning as it is perceived by the individual (a detailed analysis of this point will be considered as the chapter progresses). The contextual nature of the individual's total functioning has a significant influence on any psychiatric definition. An individual might be defined as mentally ill either by his personal definition of what constitutes his total functional disturbance or by 'other's' claims. 'Other's' definition might reflect: 1) the nature of psychiatric diagnosis currently used in specific context, or 2) the establishment's system of values where the psychiatrist works, or 3) the model of mental illness which the psychiatrist adheres to or 4) the state's own set of norms which has a significant feedback for any psychiatric definition.

Now, Mr. Plyushch could not be viewed as suffering from any total functional failure simply because he has been rejected

by the psychiatrist or perhaps by his wife. Such rejection if it occurs, might be the result of a plausible-sounding psychiatric rationalisation of his deviancy and must not be taken as a sufficient condition for labelling him as mentally ill. As Boorse in Edwards (1982) pointed out, even total rejection by everyone cannot in itself guarantee a pathological condition, though it might produce one. It must be emphasized here that being rejected does not necessarily indicate 'abnormality' or 'disease' or confirm or validate Plyushch's own suffering. The black were rejected in the U.S.A. and are still rejected in South Africa but that does not make them schizophrenic.

No doubt being rejected by a wide range of societal sections could result in psycho-social functional failure and possibly physiological failure (not being able to secure their living resources, etc.). One would wonder whether it is justifiable or humanistic to safeguard the individual from this total rejection by diagnosing him as 'schizophrenic' with its totally destructive consequences (compulsory admission, use of powerful drugs, the attribution of a sick role which might lead to a negative self-image of impairment, etc.). In any case, the individual has been rejected as a political dissenter before being admitted to the mental hospital, and, after being discharged, as an 'ex-mental patient'.

Now, although the RFD model may not lead immediately to the development of an effective method in dealing with the psychiatric abuse in the Soviet Union, it may at least provide the first step in that direction. In order to illustrate this point, it would be

useful to analyse the psychiatric intervention to which Mr. Plyushch was subjected in the light of the above model. In the case of Mr. Plyushch it is crucial to consider the totality of failure in both psychological and social function as a necessary condition for such intervention. If one considers Mr. Plyushch's total level of functioning, it would be seen that this was not sufficiently disturbed to merit psychiatric intervention (see Koryagin, 1989). On the physiological level, the above case did not show any disturbance in behavioural goals, considered to be vital in the maintenance of his life (e.g. he didn't show any sort of eating disorders, sleep disturbance or physical activities that might endanger him or others).

On the psycho-social level, it is evident that the patient shows great awareness of his country's political situation and the rights of the disadvantaged. Moreover, he has made a significant scientific contribution within his work as a mathematician. His letters and conversation with the psychiatrist in charge - as reported by Wing (1978) was coherent and highly intelligible. His wife and friends regarded him as a normal individual with a great sensitivity to his country's problem.

A careful examination of Mr. Plyushch's total level of functioning would reveal that his only problem is his adherence to specific beliefs and thoughts which are considered to be deviant from the traditional set of thoughts to which most 'normal' or 'sane' Russians adhere. Thus, the patient is abnormal because according to the Soviet diagnostic system, he is manifesting a "poor adaptation

to the social environment" accompanied by "social dangerousness" or "over-estimation of his own personality" which implies a delusion concerning his ability to reform society or, in other words, grandiose features. Diagnosing him as 'abnormal' or 'schizophrenic' does not mean necessarily that the patient displays an observable set of 'psychotic symptoms' or, in Wing's (1978) own words, "technical evidence". Admitting Mr. Plyushch to the SPH was justified on the basis that he constitutes an 'extreme social danger' and on the basis that although he seems to be normal, in fact, there are genetic or organic factors that make his abnormality theoretically if not clinically present (see Merskey and Shafran, 1986).

The above concept of abnormality held by many Soviet psychiatrists has resulted in viewing the patient's thoughts and behaviour as incomprehensible or unpredictable or delusional and hence, abnormal. Not understanding Mr. Plyushch's thoughts and beliefs does not mean that his thoughts are wrong or delusional or dangerous and cannot be a sufficient condition for labelling him as 'abnormal' on the basis of a diagnostic scheme which does not fully express the uniqueness of each individual case and his ability to function in spite of his suffering. Moreover, such a scheme cannot fully estimate the nature and content of the individual's thoughts or behaviour yet regards thoughts which do not exactly match socially accepted political or social norms as irrational, and thus falling within the categories of psychopathological conditions.

The possible alternative would be to incorporate the concept of 'reactiveness' as a crucial factor in evaluating the disturbed function. Thus, instead of viewing Mr. Plyushch's political attitudes as a reflection of a 'disease' controlled by unknown genetic disturbance, the alternative would be to view Mr. Plyushch's "reformist delusional idea" (on the assumption that he is really suffering from such ideas) as a reaction or a process that occurs as a result of a continuous confrontation between the individual patient and external environmental events occurring outside him (Laing and Esterson, 1970).

The emphasis here is on 'abnormality' as related to the individual's major functions perceived by himself and not just to unspecified and ambiguous 'symptoms' that are generally claimed by others. The patient's own perception of his total functioning would give rise to the importance of his claim, which should be regarded as an appropriate and applicable determining criterion concerning the severity of the individual's problem and thus his need for psychiatric hospitalisation. What actually happens is that many political dissenters are admitted to psychiatric hospitals on the basis of 'others' claims rather than their own claims. In many cases, psychiatric hospitalisation or services "come into being not because the alleged patient wants or is willing to submit to it, but because someone other than the 'patient' claims that the 'patient' is mentally ill" (Szasz, 1984, p.17). In support of Szasz's arguments, when Dr. Koryagin (liberal Russian psychiatrist) examined some political dissenters, he concluded that:

> "None of them sought medical assistance, their families did not ask for psychiatric help, their speech and behaviour posed no threat to anyone; nonetheless, they were all confined to psychiatric hospitals by force or by deception." (1985, p.175)

Although, in general terms, the claims of others are decisive in practice - and in some central cases have to be - the importance of the 'patient's' verbal or personal account of his suffering should also be taken into consideration. That is because the individual's own perception about his past and present functioning might possibly indicate that his present level of functioning, even though not fully effective, is much better than his past functioning which is far worse.

The emphasis on the importance of the 'patient's' past and present functioning as it is experienced by himself emerges from the following premise:
First, the individual patient is the ultimate expert in his total functioning. Thus, allowing the person's own assessment would give an indication as to whether he is really suffering or not and whether such suffering has a real rather than an attached hypothetical or theoretical negative consequence.

Others' own assessments, although subjective in nature, would be allowed in certain conditions, to enter our overall evaluation of the individual's suffering especially when his problematic behaviour represents a real or significant departure from the healthy norms in his society and might affect the well-being of others. One might

argue that in the Soviet context, reformist or dissent behaviour certainly has been dangerous both to the individual and to his friends and family. To defy the power of the KGB could be interpreted to mean that the 'patient' does not have a rational estimation of the possible tragic consequences of such confrontation and the possible negative outcomes on his family. However, many Soviet dissenters have only too rational an idea of the consequences of confronting the State but are prepared to sacrifice their own safety and that of their families on moral, spiritual and humanitarian grounds.

Throughout this chapter, we will try to look into the different ways in which behaviour is considered to be dangerous and how it is crucial to differentiate between a real irrational dangerousness and 'dangerousness' that is simply 'attached' by 'others' to discredit one's thought and values.

Secondly, an effective screening of the 'patient's' total functioning would be achieved through a mutual agreement between both the 'patient' and the psychiatrist on the methods of evaluating such total functioning. Surely this procedure is much more effective than comparing the functional ability of Mr. Plyushch, for example, to an 'average' or theoretical normal Russian citizen. The positive effect about such mutual agreement on the methods of screening is that the emphasis would be shifted towards evaluating the 'patient' as a unique person. That is to say that other's definition would be replaced or supplemented by the patient's own definition. As a result, the psychiatrist's diagnosis would not be based on whether

Plyushch had schizophrenia or not. On the contrary, such diagnosis would be established according to what both the psychiatrist and the patient agree on what constitutes the patient's past and present total functioning. The psychiatrist's decision, accordingly, would be directed towards specifying the main characteristics of Mr. Plyushch, for example, total functional activities in different spheres of his life.

Finally, to fulfil the above premise, the psychiatrist should be ready to accept the fact that patients, even if disturbed, are nevertheless prima facie autonomous. Accordingly, a rational autonomous diagnostic and therapeutic relationship is the central safeguard in any systematic procedure to differentiate between what counts as real suffering that is perceived or defined by the 'patient' himself and an artificial definition by 'others' who might have little or no understanding of and familiarity with the patient's past and present functioning (see Koryagin, 1989).

Now let us consider another case illustration in order to give a full account of the importance of the 'patient's' personal claim and the claim requirement principle in general which represents a central theme in the RFD model.

Mr. Pyotr Grigorenko's case (which was presented by Bloch and Reddaway, 1977, pp.105-127) provides an excellent illustration of psychiatric abuse in the Soviet Union and the appropriateness of the RFD model in solving the problem. In 1927, when Grigorenko

was 20 years old, he joined the Communist youth league (political party). Two years later he became known as a distinguished and gifted student in "Kharkov Polytechnic Institute" for military science. As a result, he was recommended by the authorities to a highly respected engineering post in an academic setting. He graduated there in 1934 with distinction. Grigorenko had another distinctive degree from the military academy. During the Second World War, he served actively for a period of duty and as a result he was highly respected by the authorities. By 1959, he was upgraded to a major-general in the army with a prestigious academic post. He began to criticize the practice of authoritative persons in his work and their neglect of the human rights. In 1963 he established a political party in order to bring Leninist principles into light again. As a result, and with the effective help of the KGB, he was accused of anti-Soviet activities, then transferred to a psychiatric examining centre. The psychiatrists in charge reached the conclusion that Grigorenko was suffering from a "psychological illness in the form of a paranoid development of the personality involving delusions, combined with the first signs of cerebral arteriosclerosis". He was certified as incompetent and thus meriting compulsory admission to SPH. The psychiatric decision was based on the following justification:

> "His psychological condition was characterized by the presence of reformist ideas, in particular for the reorganization of the state apparatus; and this was linked with ideas of over-estimation of his own personality that reached messianic proportions. He felt his experiences with emotional intensity and was unshakeably convinced of the rightness of his actions. At the same time elements of a pathological interpretation of his surroundings were observed, together with morbid suspicion and sharply expressed excitability." (Ibid., p.107)

After spending approximately one year in SPH, he was re-examined in 1965 by a group of psychiatrists who validated the above conclusions, but pointed out that he was no longer mentally ill: "He is in remission, does not require in-patient treatment, and shows only features of sclerosis of the brain" (p.108). As a result, he succeeded in gaining a discharge from the hospital, but was advised to attend the district psychiatric clinic periodically.

After his discharge, Grigorenko became more involved in active anti-Soviet activities, especially in the field of human rights. His main concern was to free himself from the label which psychiatrists had attached to him, namely an "invalid of the second category". According to this status of invalidation he might not be permitted to work again and he must show himself to the psychiatric clinic from time to time. The KGB put him under continuous forms of surveillance. In May 1969, the KGB arrested him, he was beaten up and prevented from having any contact with his lawyer and his family. The KGB arranged to put Grigorenko under the care of psychiatrists. The first examining group of psychiatrists reached the conclusion that the patient must be considered as not suffering from any symptomatic behaviour. However, a second group of psychiatrists reached a different conclusion, which was much more acceptable to the KGB. They found him to be "suffering from a mental illness in the form of a pathological, paranoid development of the personality, with the presence of reformist ideas that have appeared in his personality, and with psychopathic features of the character ..... Consequently, the patient must be considered not responsible" (Ibid., pp.112-113). Thus, he needed

a compulsory treatment in SPH. The psychiatrist who wrote the above reports believed that Grigorenko's former level of positive effective psychosocial functioning "is a characteristic of a pathological development of the personality" (p.113) and thus, he merely appeared to be normal on the theoretical level whereas clinically he was abnormal, and his disturbance would be discovered in due time. Finally, Grigorenko was admitted to SPH and considered not responsible. (For more details, see Reich, 1985; see also Merskey and Shafran, 1986; Köryagin, 1989.)

Obviously, the above patients, Mr. Grigorenko and Mr. Plyushch were admitted to mental hospital not because they were really motivated to be treated, but because the authorities defined their total life as unintelligible and unpredictable, thus as dangerous to the well-established political and social order of the country - therefore, meriting psychiatric hospitalisation.

These cases lead us to recall the principles of "claims requirement" as a possible safeguard criterion for protecting the individual's rights and for a relatively systematic procedure through which one could decide the degree of their functional failure (i.e. the severity of the patient's problem) with of course, the exception of severe psychiatric conditions where one would hardly expect self-referral or acknowledgement of the patient's own disturbance.

As pointed out in Chapter 3, self-referral behaviour for a Kuwait patient, for example, might differ crucially from that of

a British patient. Generally speaking, self-referral might indicate that the functional failure is partial rather than total and this condition might be applied to the British patient. For a Muslim patient, however, where long-term suffering is considered to be an ordeal which brings expiation for sins and raises the patient to a higher rank among believers if he accepts the 'disease' with dignity, self-referral might possibly imply the presence of a significant functional failure.

In Kuwait, for example, the situation is aggravated by a negative attitude held by the public towards psychiatric services in general. Thus, when an individual applies for psychiatric help, in spite of all the negative consequences, this application per se is an indication that first, his suffering has become unmanageable, even if at the onset the problem had been only partial. Second, the patient who has voluntarily sought psychiatric help is much more likely to benefit from 'psychiatric treatment', because he is obviously motivated to improve. Thus, the individual personal claim for psychiatric help might possibly be taken as an additional important indicator, besides other psychiatric examination methods, of the severity of his disturbance in the three major functions.

Now, what about the patient who experiences total failure in his major functions but is unable, for various reasons, to apply for psychiatric help and is also perhaps causing suffering to the people around him? In such a case it would be justifiable for mental health professionals to consider the claims of the family or others,

but it must be strongly emphasised here that people working in the psychiatric field have a professional and moral obligation to validate such claims by, for example, engaging in field research visits to the patient's home and work environment. Such visits, accompanied by a careful and systematic observation would give the mental health professionals first-hand experience of the patient's actual ability to function and would be a sufficient criterion in deciding whether the patient is really suffering from total or only from partial functional failure. Of course, writers such as Thomas Szasz would react negatively to any possibility of accepting the 'others' claims and would consequently suggest that no one must be sent or in Szasz's own terms, dragged to a building called a 'mental hospital' against his will unless he committed a crime. For Szasz, in a free society, the psychiatrist does not have the right to diagnose someone who does not want to be diagnosed. (After Dark, a TV interview with Thomas Szasz, 1988.) However, Szasz's argument seems to ignore the fact that there are specific psychiatric conditions where one must allow for certain exceptions.

Now, what are the exemptions of the "claims requirement" principles? These could be listed as follows:

First, apparent aggressive behaviour:
The psychiatrist has a professional obligation to accept the 'others' claims when the 'patient' is showing demonstrable physically violent behaviour towards himself or the others. (It's worth mentioning here that there is a section in the British Mental Health Act, 1983, where the police can pick up a person from the street if there is

'evidence' of an "urgent treatment need" or if the person 'appears' to the police as suffering from some sort of mental illness. (See Section 136 of the Mental Health Act (1983). But one must bear in mind that in many cases, aggressive behaviour is a mere reflection of the pressures put on the patient to admit himself to a mental hospital. Moreover, the committal procedures (within the police force or the hospital) could be the cause of the patient's aggressive behaviour. Therefore, a careful analysis of the nature, the context, the intensity, and the duration of the individual's aggressive behaviour is a necessary requirement for a reliable validation of the other's claims. Furthermore, if one has to base one's definition of mental illness on 'irrational violent behaviour', it must be clear that there is compelling evidence in many parts of the world, indicating that the hospital staff is much more aggressive and violent than the mentally aggressive patients themselves. As a result, the 'patient's' violent behaviour might be a rational response to the staff's aggressive attitudes or conduct.

Secondly, psychopathic deviation:
Psychopathic disorders are expressed by abnormally aggressive or seriously irrational behaviour. The question which arises in this respect is: how to draw a line between the rational or normal aggressiveness and the irrational. A dissenter who hijacks a plane with the aim of emigrating from the Soviet Union is unlike a person who kills haphazardly in a crowded street. Thus, the RFD model accepts both the claim of the individual patient himself and others' claims bearing in mind that accepting the others' claims must involve the following:

1) noticeable and persistent evidence of the seriously aggressive behaviour;

2) bizarre violence, i.e. violence which lacks a purposeful or understandable aim ('sane' rather than 'mad' violence, Rack, 1982).

What needs to be stressed here is that people may manifest violence at specific times in their life and in a justified response to certain situations but not in others. Such purposive violence, in many instances, must be dealt with not by the psychiatric institution, but by other judicial channels (see Szasz, in After Dark programme, 1988). That is to say that 'a purposive' violence committed in pursuit of a robbery, for example, would be a suitable case for the police rather than psychiatrists. Many research papers, however, showed that being mentally ill does not mean necessarily a high potentiality for violence (see Scheff in Townsend, 1978). The problem stems from the fact that identifying mentally ill individuals with dangerousness or unpredictable violence depends mainly on the popular and generally stereotyped attitudes towards the definition of 'mental illness' as synonymous with irrational violence or bizarre killings, etc.

Finally, people who manifest a clear indication of total functional failure. In such conditions, significant 'others' claims are more likely to take precedence over the individual's personal claim. It must be emphasised here that the above exemptions do not necessarily minimize or weaken the basic premises underlying the application of the individual's verbal or self-report principles, if one bears in mind the fact that the above exemptions do not represent a majority of cases in psychiatric daily practice.

Now, when trying to apply the claims requirement principles to the Soviet context, we would discover many problematic issues regarding the individual's personal claim. Mr. Grigorenko's case is an excellent illustration of the above issues. It seems from the psychiatric examination of Mr. Grigorenko that the authorities are not willing to accept his claim under any circumstances. Thus, the patient is for them, even when discharged, "in remission". This means that even if Grigorenko shows perfect functioning in the future, he is still considered vulnerable to relapse and his claim cannot be accepted due to his vulnerability. So, "The patient is in remission" is a term which is used in the Soviet Union as a means of leaving the door open for another admission to hospital (revolving door phenomenon). The Soviet psychiatric authorities are presumably refusing to validate the 'patient's' claim on the basis that he is irresponsible, does not know his own best interests, suffers from illogical thoughts about his country, and thus is dangerous to himself and others. One might have a rational discussion with the psychiatrist in charge of the case in order to get a clear picture of the clinical reality of the above case. But what actually goes on in Grigorenko's case and many other cases is that the KGB is the final authority in deciding the acceptance or the refusal of claims or even in deciding the kind of diagnosis.

The KGB refused the opinion of the first group of psychiatrists who examined Grigorenko because they (the psychiatrists) reached the conclusion that "the patient must be considered as free from any symptoms of mental illness" and thus able to make a valid claim on

his own behalf. Another group of Soviet psychiatrists reached another kind of result, which was much more acceptable to the KGB. This group believed that Grigorenko was mentally ill and suffered from a pathological interpretation of his surroundings. Thus any future claims from the patient were invalid because, again, he was considered to be in "remission". Now, the Soviet authorities, in order to invalidate the individual's claim, usually use the concept of schizophrenia rather than the "psychopath" class. A careful analysis of the term "psychopath", especially the paranoid psychopath (which is the most commonly used term), as it is expressed in many textbooks of Soviet forensic psychiatry, would reveal that Soviet psychiatrists define the paranoid psychopath as:

> "... a disorder of personality, congenitally determined or acquired early in life. The abnormal features may, however, manifest themselves at any time in life. ..... Their projects and plans usually reveal the narrow range of their interests and knowledge ..... In the forensic context the paranoid personality can usually evaluate external reality and govern his actions and is thus declared responsible. Exceptionally, the condition is so deep ..... that it constitutes a mental illness in which the patient is then declared not responsible." (Felinskaya in Bloch and Reddaway, 1977, p.243)

Thus, diagnosing a person as a 'psychopath' does not necessarily lead the authorities to discredit his claim completely. Grigorenko and many dissenters receive the diagnosis of schizophrenia rather than psychopathic deviation because the case histories of Grigorenko and others show perfect functioning. Their case histories show no sign of psychopathological indications that usually correspond to any psychiatric definition of the psychopath or psychotic

conditions in general. In fact, most of them have shown during their childhood a successful ability to communicate, leadership, good grades at school, "independent judgments and determination in overcoming difficulties" (Klose and Koryagin, 1985, p.175). Thus, placing Mr. Grigorenko in the category of "schizophrenia" rather than "psychopathic disorder" implies that his "mental" condition misrepresents his capacity to evaluate the world around him realistically. In other words, he is out of touch with reality, therefore his claim is invalid.

Now, one might argue that Grigorenko's reformist ideas would lead to negative consequences in terms of disturbing the established order in society and causing discomfort to those surrounding him, hence, ultimately, to himself. Accordingly, it is legitimate to argue that he is 'suffering' and in need of 'psychiatric treatment'.

In fact, although the RFD model places a great emphasis on the centrality of how the disturbed behaviour receives different forms of interpretation, the analysis of the interpretation process requires further consideration. Included in such a consideration, is whether the context alone in which the problematic behaviour occurs is a sufficient condition for judging the abnormality of behaviour? Grigorenko's case provides a good illustration of how the contextual nature of behaviour needs to be reconsidered, especially when one takes into account the political abuse of psychiatry in many parts of the world.

In both our cases, and in many other cases, the people around the dissenters do not have any impression that they are really 'insane'. Moreover, different groups of psychiatrists believe that political dissent per se is not the same as mental illness, but they are "too conformist to refuse to participate when called upon" (Bloch and Reddaway, 1985, p.160). The dissenter's past and present 'mental efficiency' does not indicate any abnormality. In fact, most of them (as in Grigorenko's case) were more likely to adhere to their political beliefs even after being discharged from the mental hospital, which implies the presence of an unshakeable and consistent system of values. It must be emphasized here that most of the dissenters (our case is not included) who spent a long-term confinement in mental hospital, and who were interviewed by Dr. Koryagin (a liberal Soviet psychiatrist) refused to accept the psychiatrist's definition of their former opinions and behaviour as representing symptoms of 'schizophrenia'. This is presumably because most of them believed that they were railroaded into OPH or SPH (including our case), for no reason other than their thoughts were different from those of the 'average' hypothetical person. In other words, they didn't regard themselves as 'mentally ill' (see Klose and Koryagin, 1985).

The above discussion highlights the nature of psychiatric interpretation. The RFD model throws light on two forms of interpretation: 1) an interpretation that standardly implies a meaning different from the individual actual functioning. This kind of interpretation is currently used by people other than the individual himself such as psychiatrists, family, etc., 2) the individual's interpretation

of his own functioning. This kind of interpretation standardly reflects how the individual perceives and experiences his total functioning.

Again, 'homosexuality' provides us with a good example of the nature of the interpretative process in psychiatry and its implications. In the past, the psychiatrist who used the term 'homosexual' implied that the affected individual is sexually unfit or there is something the matter or wrong with him or incapacitated, etc. (Farrell, 1979).

At present, the term 'homosexuality' gives a different standard implication, i.e. a preference rather than a psychosexual disorder. Thus, what mental health professionals are dealing with are interpretations which have a relative nature and a different set of implications.

Now, what is the relationship between the interpretative process of a given behaviour on the one hand and the patient's claim on the other hand? Furthermore, how does the inclusion of the above issues into the RFD model contribute to solving psychiatric abuse in the Soviet Union?

In answering the above question, let us again consider the previous two cases, Plyushch and Grigorenko. Both cases were viewed by Soviet authorities as manifesting dissenting behaviour which standardly implies the meaning of deviance, social misfit and

hence, 'diseased' individuals. The problem is that, as already mentioned in previous chapters, the interpretation of the individual suffering as 'abnormal' would have a long-term consequence even if the patient is fully cured. For Soviet psychiatrists, the fully cured 'patient' seems 'normal', acts as if normal, but in fact, is abnormal. It seems crucial to remember here that the above practice is not exclusively related to the Soviet psychiatrist. In the DSM-III, for example, the recovered schizophrenic patient would be viewed as being "in remission" rather than being fully cured.

Now, let us examine how psychiatric interpretation works on both cases and the consequences as they appear on the claim requirement principles:

Plyushch "first rank symptoms"	Grigorenko "first rank symptoms"	The individual's personal interpretation	The authorities - psychiatrists' interpretations
1) Writing letters on human rights. 2) Established a group for the defence of human rights and to work for the democratization of his country.	1) Criticized the practice of the authoritative person in his work. 2) Then became a human rights activist.	1) Both cases, as in many other cases, believed that they have an insight and awareness of the social and political surroundings of their society. Such awareness, according to their claim, is justified by the presence of well-established evidence of violation of human rights. Their families and their friends regard them as completely normal, coherent, intelligent. International psychiatric authorities support the validity of their claim and consider them fully normal.	All the dissenters including our both cases show a pathological interpretation of their surrounding delusional reform idea and are thus, "schizophrenics".

A careful examination of the above table will lead us to the conclusion that it is difficult, if not impossible, to make any sort of matching between the 'symptoms' interpretations of the individuals on the one hand and the Soviet authorities (psychiatrists), on the other. In the Soviet Union, it is not the labelled individual or their social reference groups who consider their behaviour as manifesting distress or a sign of 'abnormality', but the KGB and some groups of psychiatrists who make the diagnosis and provide the treatment.

Now, if we imagined that all Soviet citizens were totally convinced that 'political dissent' is a form of 'disease', the question arises: Can we accept the possibility that 'political dissent' is a real 'disease' and thus Plyushch and Grigorenko must be viewed as 'abnormal' individuals?

To answer the above question, consider the following story of the American psychiatric system. Roughly 100 or 150 years ago before the American Civil War around 1835 or 1840, there was a medical paper published and widely accepted in the medical literature about mental disease called "Drapetomania" (drapetes, runaway + mania disease) (Blakiston's Gould Medical Dictionary, Fourth Edition, 1979, p.409).

This disease was basically applied to black slaves who tried to escape from slavery in Mississippi and Louisiana to North and Canada. The 'slaves' who wished to be free were diagnosed as suffering from 'Drapetomania'. This 'disease' was in the medical

dictionaries until nearly twenty years ago when it was taken out in embarrassment (Thomas Szasz, After Dark, 1988).

Clearly, the definition of such 'disease' reflects the kind of values and attitudes that were held by many Americans at that time towards the genetically determined or inheritance inferiority of blacks. Now, was the total rejection of the blacks at that time a sufficient condition for defining their 'will to be free' as "Drapetomania"?

In answering the above question, one must bear in mind the following two points:

1) What are the 'real' motives which bring about or cause the psychiatric labels of blacks?
2) How does the individual get the label or the definition in the first place?

Surely, the definition of the black as suffering from some sort of genetic defect is coloured by political and social policy towards them (cheap labour, for example). That is to say that the psychiatric definition in the case of blacks is basically a political attempt which reflects the desire of a particular group rather than a scientific and objective endeavour.

Another possible reason for labelling the black is cultural or popular stereotyped attitudes towards the black as someone who is violent, simple-minded, emotional, etc. What follows from

such an image is that blacks are viewed as more vulnerable to disease or irresponsible acts such as escaping from their masters. Thus, the "powerful effect of expectations" (Townsend, 1978, p.116) and popular stereotypes towards the black might possibly act as a guideline for clinicians to shape the symptoms of 'Drapetomania' or mental illness in general (Scheff, in Townsend, 1978).

Nowadays, when the values and attitudes of American's society have changed, blacks are beginning to be viewed as 'normal' individuals. What does that mean? It simply means that, if 'Drapetomania' is a true disease with a clear-cut pathological indication, no new 'values' would affect the presence or absence of the disease. By contrast, many HIV positive patients have been rejected and discriminated against in their work, etc. Now, if society changes its values and attitudes towards AIDS patients in terms of accepting rather than rejecting them, would that motivate the pathologists to take out HIV disease from the medical dictionaries? Surely not. Whether there is total rejection or total acceptance towards the AIDS patient, no one could deny or ignore the reality of such disease, i.e. clear-cut pathological manifestation. This means that the diagnosis of mental illness is determined in many instances by moral or political values which are, in many cases, irrelevant to the individual's actual suffering. Thus, total rejection of a mentally ill individual cannot always be taken as exclusive evidence that the society is right and the 'patient' is wrong. Another factor that needs to be considered beside the contextual nature of any given disturbed function is whether the individual is really suffering

or whether his suffering is attached or assumed by others. This will lead us to emphasise the importance of which individual receives the label in the first place. In most British mental hospitals, for example, there is an over-representation of Afro-Caribbean groups who are more likely to be involuntarily hospitalised, sent to locked wards, and receive ECT (see Fernando, 1988). The process of their admission goes like that:

> "... no-one goes to a psychiatrist unless they are 'mad', and no-one is designated 'mad' unless they are violent. A person who is mentally disturbed but not violent is not 'mad'."
> (Rack, 1982, p.171)

For many British psychiatrists, being Afro-Caribbean means that the patient is presupposed to "... look and act in a bizarre way" (Ibid., p.117) or in a violent way and hence to be vulnerable to schizophrenia. No matter whether the violence in question is mad or sane violence, once the black is brought to the hospital by the police, the psychiatrist in charge is pre-conditioned to assume the worst by the label schizophrenia which the person carries with him. The psychiatrist expects to see a schizophrenic rather than someone who might have schizophrenia. Now, is the over-representation of Afro-Caribbeans (or Indians or Pakistanis) in mental hospitals a sufficient indicator that they are 'really' schizophrenics, for example?

Certainly not, if one bears in mind that most of them are identified or admitted through the police. Thus, new research is studying Afro-Caribbean communities in the hope of discovering how

such people receive the label 'schizophrenia' in the first place, rather than of discovering any specific pathology in this group. Knowing the pathways through which a person receives a psychiatric definition would illuminate the factors that govern societal acceptance or rejection of any group of peoples.

It must be re-emphasised in this respect that we do not undermine the importance of the contextual nature of any given disturbed function. The problem on a large scale is that such contextual interpretation must be considered in relation to the individual's actual functioning, the reality of his suffering and how he receives the label.

It must be stressed here that the individual's suffering cannot be defined simply by the dangerous consequences of reformism, for example, in the context of a police state.

The motivation to succeed in life can cause suffering due to the presence of certain negative consequences such as conflicts with people, anxiety, ignoring family duties, etc. Suffering in this context cannot be considered as a negative symptom or indication of mental disturbance or irrationality. The suffering of Soviet political dissenters will surely be alleviated if the political situation in their country improves. Similarly, the suffering of the individual who is striving for success will disappear when he fulfils his aims. This leads us to the following conclusion; if the individual's suffering can respond positively to change in his social

or physical environment then there is no real suffering (see Culver and Gert in Brown, 1985). The most important element in any form of suffering is "... the attitude we take toward suffering, the attitude in which we take suffering upon ourselves" (Frankl, 1988, p.114).

What we need to emphasise as a result of the above discussion is the need to draw a line between "... what a society considers/should consider sufficiently autonomous and what the same society considers/ should consider sufficiently defective in autonomy" (Laor, 1982, p.221).

Now, let us relate the above discussion to Mr. Plyushch's and Mr. Grigorenko's theoretical abnormality. The RFD model believes that both cases could be viewed on the following basis: First, both cases show in their past and present history a total functional effectiveness. A necessary requirement for the application of the RFD model is that the individual's total and not just partial functioning must be disturbed. Neither case manifested even a partial function failure.

Secondly, both cases show a significant total functional failure when looked upon within the psychiatric interpretation attached to their total functioning. The RFD model, on the other hand, would view both Plyushch and Grigorenko, when considering their own personal interpretations and when taking into account their past and present performance, as effectively functioning in all major functions.

Now, one might claim that their concern for rights and freedoms shows 'responsibility' is a Western political claim. Such concerns might, in the context of a police state, be the height of irresponsibility. Moreover, it is not inconceivable that there could be a society where individual autonomy was strongly disvalued and felt to be threatening. Advocating freedom would certainly seem irresponsible here.

Our response to the above argument begins by the following question: "How do we distinguish between autonomous and non-autonomous behavior?" (Murphy, 1982, p.333; see also Leor, 1982), or how do we differentiate between a totally responsible act and a partially responsible one? In fact, it is difficult, if not impossible, to give a logical answer to the above questions because:

> "... one would still, in establishing the conditions of autonomy, be establishing moral conditions in labeling and naming some conditions impediments and others as legitimate grounds of choice." (Ibid., p.334)

Now, could we consider the political dissenter's beliefs as not wholly responsible and hence irrational? Brown (1985) provides us in his article "A critique of three conceptions of mental illness" with a convincing argument by stating that our

> "... beliefs are arrived at and shared not on the basis of evidence or argument but by virtue of psychological and social factors involving our membership in or exclusion from various social groups and practices. Indeed those beliefs most often cited as delusionary are of just the sort

> least amenable to evidential warranty and most likely to fall under sub-rubrics as religious, mystical, political, or metaphysical, but not under those of biological, medical, sickness, illness, or disease. There seems little, therefore, in the beliefs themselves, however crazy, to warrant the designation of sick or diseased, except that some or even nearly everyone may reject them as contrary to evidence, good sense, current views, or community consensus, and none of these considerations seems at all like those that would be adduced to determine the presence of a physical illness or disease." (p.559)

What is wrong with Soviet psychiatric practice is that political beliefs and the dissenters' sense of responsibility is taken to imply, for example, as forms of 'chronic hypomania' (a form of illness) in which the patient "... liked dealing with people and organising different activities" (Moroz in Merskey and Shafran, 1986, p.250) and in addition, they are motivated to:

> "Inventing and improving plans, the patients were fully engulfed in work, did not rest on weekends and holidays, and could talk only about their 'hobbies' because other topics seemed boring to them. The patients were firmly convinced that their activity was interesting for everybody and did not allow any irony regarding their work. In some cases the content of over-valued ideas was outside their main occupation."
> (Moroz in Merskey and Shafran, 1986, p.250)

What we conclude from our previous discussion is that the belief per se, whether a moral or political one, is not a sufficient condition for labelling a person as mentally ill. (This point will be elaborated later in this chapter).

For those who emphasise the moral centrality of autonomy, the conclusion is clear:- whether a given society values or disvalues the principle of autonomy or the individual sense of responsibility, such an ethical principle must nevertheless always be respected and promoted in clinical practice. The only exceptions are in a severe psychiatric condition where there is a clear indication of a temporary defective in autonomy and where the individual's behaviour represents a significant threat to himself and to the well-being of others.

Thirdly, if we believed that both cases according to their own perception or interpretation - have a significant total functional failure, the RFD model would strongly emphasize the concept of "reactiveness" of the disturbance. Adherence to the concept of reactiveness would lead to the view that the 'abnormality' in both cases, rather than subsisting inside the persons, is in fact, a reaction to external causes which occur outside them. Thus, the emphasis would be on the events that occur in the environment rather than on a mentalistic or genetic internal explanation.

Finally, it was well-documented from the case histories of many political dissenters including our two cases, that none of them cause suffering to others or have feelings of 'distress'. This leads the RFD model to emphasise the importance of the individual's own estimation of the "degree of suffering" as a central criterion in deciding whether the 'patient' needs to be hospitalised or not. Most political dissenters create a positive meaning through their suffering (helping others, sacrificing their futures for the sake of others, interests, etc.). They may well suffer, but it could

be rational and meaningful to do so. Frankel (1988) expresses throughout his book "Man's Search for Meaning" the above point very well by stating:

> "Man's search for meaning is a primary force in his life and not a "secondary rationalization" of instinctual drives. This meaning is unique and specific in that it must and can be fulfilled by him alone; only then does it achieve significance which will satisfy his own will to meaning. There are some authors who contend that meaning and values are "nothing but defence mechanisms, reaction formations and sublimations". But as for myself, I would not be willing to live merely for the sake of my "defense mechanisms", nor would I be ready to die merely for the sake of my "reaction formations". Man, however, is able to live and even to die for the sake of his ideals and values." (p.99)

When the degree of suffering, however, becomes severe, as a result of a continuous contradiction and inconsistency between the individual's subjective meaning of his suffering and the socio-professional interpretation (see Laing in Delbaum, 1972), it is likely that such situation would place the sufferer into a long-term disadvantage status in which meaningful suffering becomes protracted to the point of loss of meaning which could cause the person a total functional failure.

Clearly, the applicability of the RFD model is restricted basically to functional failure as it is perceived by the individual himself. A crucial question in this respect is why we should consider the individual's personal interpretation of his total functions as more valid and reliable than the interpretation of others.

As we have mentioned in previous chapters, psychiatrists are basically dealing with feelings, emotions, memory, subjective experience, conscious and unconscious desires, conflicts, insight, thoughts, etc. The content and frames of their judgments are centred on whether the above feelings and desires are appropriate or inappropriate, reasonable or unreasonable, intelligible or inintelligible, real or out of touch with reality, bizarre or sound, efficient or inefficient. Psychiatrists' instruments are not developed to a degree where they can detect subjective experience and feelings in an objective and systematic way. We are not dealing with a well-established biological system with specific measurable functions that can be identified by physical methods. This has led writers such as Boorse in Edwards (1982), for example, to base their view of mental illness on internal malfunctioning. For Boorse, there are mental functional norms, not identical with biological norms, but plausibly viewed as working on a similar basis. Kendell's studies (1975) led him to assume that mental disease can cause survival and reproduction problems. Kendell's model served well to support Boorse's basic arguments of the similarities between mental and biological functions. Unfortunately, the problem is still there. Plyushch's political 'attitudes', for example, might be perceived by Boorse as representing a disturbance in his mental functional forms that can be understood as relatively similar to biological dysfunctional forms. Such kinds of beliefs are likely to increase the person's chances to be under the scrutiny of the KGB's own standards of evaluation and hence to be sent to SPH or to prison which might cause him a general deterioration in his physical and psychological health.

The KGB procedures might increase his chances of mortality. Yet, Plyushch's political or ethical attitudes are not disease.

Again, what mental health professionals are dealing with is a unique subjective condition in the context of society, rather than internal mental functional norms or psychological machinery that have a specific statistical norm and identified boundaries. It is not a matter of causing mortality or reproduction problems that make the case a psychiatric one. "Man is not fully conditioned and determined, but rather determines himself whether he gives in to conditions or stands up to them" (Frankel, 1988, p.132).

What we conclude from the above discussion is that the individual's own assessment of his life must be taken as a valid insight when trying to make sense of the subjective content of his behaviour. As Flew in Hasker (1977) argues, the diagnosis of mental illness must be based on conditions that inhibit capacities and must be "regarded by the patient as in itself and by his standards bad" (p.119) and not by the social authorities standards. In reality, however, one cannot ignore the fact that there are certain severe forms of 'mental illness' where the patient's own subjective standard requires psychiatrists diagnosis. Fortunately, not all psychiatric conditions represent a severe defect in the individual's reasoning abilities.

Let us for a moment sidestep the above arguments and try to see whether there is any possibility of establishing a value-free

view of 'dissenting' behaviour or mental illness in general.

One cannot escape the fact that the individual's personal values, subjective experience, and his cognitive pattern have a crucial bearing on defining the reality of his suffering. Most mental health professionals are afraid to admit that their definition of mental illness is not totally an objective process or free from prejudgment thoughts concerning what constitutes an ideal functioning. Instead, the definition is essentially a social process. 'Schizophrenics' in Kuwait society, for example, go undiscovered for many years because the family's toleration standards for impaired behaviour are greater than in Britain for example, where the vocational and familial demands are greater than in developing countries. In fact, the more the patient has strong family relations, high social and work status, the more 'negotiation' would be conducted before deciding to label him as schizophrenic, for example (Strauss and Carpenter in Townsend, 1978). Thus, the family attitudes, the individual's social status, and society's norms might contribute significantly in shaping the psychiatric definition or view of a given individual.

It is evident by now that it is very difficult to conceive a sharp dividing line between personal moral values and symptoms per se as an objective element. In other words, one cannot easily divorce or separate subjective experience and values from the disturbed condition in itself as something objective. Moreover, current psychiatric diagnostic tools have not yet reached a degree of sensitivity that can isolate such personal and subjective values. That is not

to say that the present writer is completely in agreement with Szasz's argument that psychiatry is completely governed by moral and ethical values.

Many distinguished authorities (Lewis, 1953; Farrell, 1979; Kendell, 1975; Laing, 1960; Szasz, 1987; Leiffer, 1969; Scheff, 1970) have found that it is difficult if not altogether impossible to establish a value-free procedure in the definition of personal and subjective values. The present writer agrees with the above authors that it is very difficult to adopt a view of mental illness that implies a standard method of dealing with every individual patient regardless of the content of his political, moral or idiosyncratic attitudes towards himself or his society or social group.

The RFD model emphasizes the view that to consider someone as 'mentally ill', his total motivational and cognitive abilities must deteriorate to the point where they impair the individual's well-being. The total functional failure must interfere with the individual's optimal functioning, survival and his own maintenance. Accordingly, any total disturbance in the individual's major functioning, especially the physiological one, which can cause a negative outcome in relation to his survival and well-being, might be internationally recognized but not necessarily value-free.

Consider a mother who kills her only baby or a person who pours gasoline over his old father and sets him on fire. Both cases will be recognized as 'patients' in almost all societies simply because at first sight their behaviour violates standard values.

Surely, dissenting behaviour per se does not necessarily violate standard values in all societies in the same sense. What actually violates the standard values of nearly all societies, however, is the nature of Soviet psychiatric interpretation which is attached to the content and frame of the dissenting behaviour. Such Soviet psychiatric interpretation is not basically tied to the underlying process of 'schizophrenia' which as mentioned earlier can be established in recognisable though distinguishable varieties, in all societies.

It is in an illegitimate sense that Soviet psychiatric interpretation represents underlying values and beliefs in Soviet society, as Szasz claims on many occasions.

When examining the Soviet context, it seems clear that the psychiatric interpretation or values that are basically held by main-stream or 'core' psychiatrists differs crucially from that of the 'average' psychiatrists and the general public.

To solve the above problem, the present writer proposes the following criteria for deciding the normality of the Soviet dissenters:

First, individuals must manifest a total functional failure in the form of violent behaviour or high potentiality for loss of control, or self-defeating behaviour that has negative consequences on the individual's own survival or that of others.

Secondly, the individual's verbal or personal claim if appropriate, must be to the effect that his present conditions and symptoms placed him at a disadvantage or limited his total functional effectiveness.

Thirdly, where relevant, 'others' claims or 'third party' claims must rely on demonstrable abnormality. In that case the 'patient' must be presumed to be 'not patient' until certain basic evidence (case history) and detailed investigation about his actual total functioning are carried out. That is to say that the presence of 'first rank' indication of total functional failure is a necessary condition for labelling somebody as mentally ill.

In all cases, it must be emphasized in the case of Soviet political dissenters that bizarre thoughts or attitudes alone, as do not standardly imply, when considering the individual's total functional effectiveness, deviation, incapacitation or mental illness.

In this respect, the present writer is strongly in agreement with Szasz (1984) when he emphasizes the importance of "voluntary psychiatry" or "contractual psychiatry" or "psychiatric relations between consenting adults" (p.25).

That is to say that apart from the excluded cases already discussed, the individual who is suspected to be mentally ill should prima facie be completely free to enter a mutual agreement with the psychiatrist. Such mutual agreement between the 'patient' and 'psychiatrist' is basically centred around what a valid or real interpretation of the individual's total suffering should be. Moreover,

such psychiatric interpretation should take into account what different mentalistic terms such as delusion, out of touch with reality, hallucinations, seeming normal, etc., imply when used in everyday language. Such mutual awareness of the meaning implied in current psychiatric terms, and of the social or familial feedback in shaping the content and frame of the psychiatric definition, would surely maximize the insight into the basic features and process of the disturbed condition as something 'objective'. A detailed account of the role of mutual agreement between psychiatrist and patient in any diagnostic or therapeutic relationship will be discussed in Chapter Six.

Summary and Conclusions

The politicalization of psychiatry in the Soviet Union has become a systematic state policy that represents an obvious violation of universal human rights, a serious offence against medical ethics, and misemployment of professional knowledge and skills (Koryagin, 1989).

Soviet psychiatrists and authorities adopt a view of mental illness that is fundamentally based on the ideas and research of Andrei V. Snezhnevsky (the founder of Moscow School of Psychiatry) which led, in the 1960's to the creation of a special diagnostic system.

Snezhnevsky's understanding of mental illness prescribed for the Soviet psychiatrists a 'monochromatic vision of psychopathology' in which there is little chance for a second opinion (Reich, 1985, p.245).

The most common diagnosis in the Soviet's diagnostic scheme is either psychopathy or schizophrenia. Three forms of schizophrenia are currently in use in the Soviet's psychiatric daily practice: continuous form, recurrent form, and shiftlike form. The most frequent diagnosis is "sluggish" schizophrenia and that is due to the power of such criteria to accommodate individuals on the basis of 'non-psychotic' symptoms.

According to the Soviet system of diagnosis, a schizophrenic can be classified to one of the three forms mentioned above, with the assumption that each form has a pre-determined genetic factor (Reich, 1985).

The concept of schizophrenia and the concept of mental disorder in general have continued to raise many theoretical, philosophical and clinical problems for mental health professionals. The vulnerability of the concept of mental illness to abuse and the traditional and well-established relationship between 'mental' labelling and the process of invalidation of the individual patient are the most important negative moral features of the concept of mental illness (see Koryagin, 1989). These problems are discussed throughout this chapter in connection with the problem of psychiatric abuse and with special reference to political psychiatric abuse in the Soviet Union. It has, by now, been extensively documented that some Soviet psychiatrists deliberately use their professional training for political rather than medical purposes, i.e. they apply the concept of 'schizophrenia' to perfectly normal people (Ibid., 1989). Other psychiatrists might

unknowingly misapply the concept of 'schizophrenia'. Two main reasons explain the ill-use of psychiatry in the Soviet Union. First, the nature of the political system of the Soviet Union and, second, the nature of the Soviet definitional system which facilitates the grounds for categorizing dissent behaviour as deviant and abnormal, hence meriting psychiatric intervention (Ibid., 1989). It seems that dissenting behaviour - according to Soviet socio-political perception - is genuinely symptomatic behaviour which makes not only the KGB officer but even psychiatrists themselves believe that dissidents are in reality 'mentally ill' individuals. That is to say, labelling dissenters as 'ill' individuals is based largely on what is usual and expected in the society. In this respect, psychiatrists represent 'the establishment' in the Soviet social and political system and their main duty is to make sure that citizens are conforming to such a system.

Thus, Soviet psychiatrists' clinical decisions in terms of dissenters are determined by the criterion of non-conformity. In recent years, attempts have been made to liberalize the Soviet political climate, leading to an announcement by the Soviet Union on January 4 1988 that it was introducing a new policy which will make the psychiatric commitment of "a patently health person a criminal offence" (Psychiatric News, 1988, p.3).

In fact, many Western and Soviet human rights activists are sceptical that the above policy will bring real reform, because (1) The main figure behind these reforms is the Minister of Health,

Yevgeny Chazov, who is known for his approval and rationalization of past Soviet practice.

(2) As Ellen Mercer, director of APA's Office of International Affairs has pointed out, Soviet authorities "have a long record of signing agreements but not living up to them" (Ibid., p.3).

(3) In the opinion of Soviet psychiatrist, Anatoly Koryagin, "Violation of the laws [by the authorities] in the Soviet Union is an everyday occurrence and has nothing to do with what is in writing. They will continue to do whatever they want, and the people have no recourse if the State maintains that there has been no violation" (Ibid., p.3).

(4) The new reforms may not be retroactive, so those dissenters who are confined in (SPH) or (OPH) may not be able to benefit form the advantages of such 'new laws'.

(5) The real purpose of these reforms, as Koryagin (1989) argues, is

> "... to reduce the question of misuse of psychiatry in the Soviet Union to isolated instances. To mention only individual cases where psychiatrists have misused their professional position or where the police have done likewise would suggest there has never been any appearance in the West of former victims of Soviet misuse ..." (p.337)

(6) According to these recent reforms, Soviet authorities have released some political dissenters, but:

> "... these releases are very carefully timed, one person at a time, the aim being to extend this process of release for as long a time span as possible, so that those who monitor the process will have the impression that the situation in the Soviet Union is

> improving - literally from day to day. So you have someone released today, that is fine, someone released next week, even better, a week later, better still, so, whether you like it or not, there is a general impression in the minds of those who watch these things that there is progressive development. You must bear in mind that those who are released from psychiatric hospitals are not exonerated or rehabilitated, in either a social or diagnostic sense. They leave the hospitals branded as psychiatrically ill; they can be put back the very next day. If the government were really liberal in its aims, there would be nothing to stop them from releasing everyone like that immediately, and saying "Yes, an error was committed, we admit this. It will not be repeated again". What is happening is just what you could call a carefully calculated release of hostages, and every release gains an enormous amount in propaganda value. Recall how dissidents have been released from prison or exile; there was myself, there was Sakharov and Begun, and all this was done bit by bit, not at once. And every time a known dissident was released, the Western reaction quite obviously was, "Look, things are improving, they've released such and such". If the Soviet authorities really wanted to improve things, they would release all these prisoners and publicly apologise. That really would be an improvement - but we have not seen it yet."
> (Koryagin, 1989, p.339)

Obviously, the recent reforms in Soviet psychiatric practice, whatever its purposes, are a clear admission of the unsuitability of the existing diagnostic model and the need to consider the individual's actual functioning. Throughout this chapter, the RFD model has emphasized the need to consider both the individual's actual functioning and the nature of psychiatric interpretation attached to it in determining the nature of the disturbed functioning.

This chapter has also made an attempt to show how the RFD model might provide some guidelines for dealing with the problem of psychiatric abuse in the Soviet Union. One of these guidelines

is that mental illnesses are identified on the basis of a total disturbance in the individual's major functions (psycho-physio-social functions). Second, the disturbance is the result of a continuous interaction between the individual and external rather than internal factors (the concept of 'reactiveness'). The emphasis here is on external observable events rather than on unspecified and ambiguous internal events.

Thirdly, the importance of the individual's verbal report or of his personal claim is crucial in protecting his rights and in deciding the severity of his disturbed functioning. It was further agreed that the important principle in any psychiatric definition of the individual's assumed problem is to be fully aware of the content and frame of the functional failure and of the role of the third party in the final psychiatric definition.

Fourthly, the validity of a diagnosis of disturbed functioning must depend on a diagnostic acknowledgement of the degree of total failure (whether partial or total failure) and of how such failure is related to the individual's own survival and well-being.

Finally, we have stressed the importance of promoting and encouraging a self-referral approach and a contractual relationship between the 'patient' and psychiatrist that is based on a mutual agreement between them as to what should constitute normal or abnormal functioning. That is to say, there should be a mutually agreed definition and both parties must work towards stated well-defined goals.

If we apply the above guidelines to Mr. Plyushch and Mr. Grigorenko, for example, we see that both patients have the right to provide a personal claim or account or interpretation about their own suffering, if they are assumed to be suffering. Both patients are believed to be perfectly normal when considering their actual total functioning as it is perceived by the individuals themselves and by their social groups (such as their families, their colleagues, relatives, etc.) rather than via the psychiatric interpretation of their attitudes. Neither of them, when viewed under the RFD model, merited psychiatric hospitalisation.

CHAPTER SIX

THE CONCEPT OF MENTAL ILLNESS: VALUE-FREE OR VALUE-LADEN

THE CONCEPT OF MENTAL ILLNESS:

VALUE-FREE OR VALUE-LADEN

1. Introduction

One of the most provoking subjects that confront mental health profession is the conceptual analysis of mental illness which continues to stimulate many controversial questions. These relate to the reality and nature of mental disturbance, the methods used for diagnosing mental conditions and the moral implications of labelling people as 'mentally ill'.

Psychiatrists, psychologists, sociologists and philosophers have responded to the problems of defining mental illness in several different ways. Their main concern has been either to base evaluations on the concept of 'value-free' objective methods, as applied in physical medicine (clinical universalism), or to retain the medical model and reject mental illness for not conforming to it.

Unfortunately, the problem of objectivity and of establishing a complete value-free theory in psychiatry has not yet been resolved convincingly. This is due to the following reasons: firstly, many writers consider physiology or the general methods used in medicine as their only paradigm in any discussion of the concept of mental illness. Secondly, although some writers adopt a more moderate stance by accepting the importance of psychological factors alongside the

validity of the 'medical model', others evaluate psycho-social factors as the only important paradigm in any discussion concerning the practice of the psychiatric profession (e.g. Szasz, 1961 and 1987; Laing, 1960 and Leiffer, 1969, Scheff, 1971). A third group is mainly represented by labelling theorists such as Goffman, Lemert, Scheff, etc.). Labelling theory not supported by recent empirical studies and such a school of thought does not provide a conceptually clear account of how to define or identify people with mental symptoms or how to treat patients who actually suffer from mental disturbance. Such a theory, nevertheless, provides a moral account of mental illness. For labelling theorists, the need to protect human rights and the respect for the dignity of the individual as an autonomous agent outweighs the need to adhere to a concept of mental illness and psychiatry in general. Moreover, they highlight the moral negative outcome of labelling people as mentally ill and the negative conditions in psychiatric hospitals. They consequently hold the belief that involuntary hospitalisation must be abolished.

This chapter is going to pose the following questions: first, is the medical model itself really value-free? Second, how valid and applicable are recent attempts to establish a value-free model of mental illness? The chapter also outlines how the Reactive Functional Disorder approach to mental illness demonstrates the impossibility of establishing a value-free model of mental illness and the need for a different perspective in dealing with human experience and findings.

In the outline that follows, the RFD will be contrasted with medical and non-physical models. The proposed alternative (the RFD) will be grounded in purely psycho-social factors. Such factors are obviously incapable of any standard application of a value-free account. But the RFD does not seek freedom from such factors. Instead, its main purpose is to be systematic rather than totally objective in our conception of the psycho-social factors. The model will consider mental illness as representing a total failure in the individual's major psycho-physio-social functioning. To identify and define such total failure, there must be present a total disturbance of the individual's motivational and cognitive abilities which underline his psycho-social functioning (such a total disturbance would presumably be so clear and so radically different from the health normal functioning that can be relatively easy to identify in many contexts, not necessarily value-free towards any contextual interpretations in any given culture). Throughout the following pages, we will consider a detailed description of how a moral perspective represents a basic development in any attempt to define mental illness. As we have already established in previous chapters, RFD represents a morally preferable approach to the diagnosis and treatment of mental illness not necessarily a major conceptual advance over the DSM-III.

In the following chapter the terms 'systematic' or 'conceptually clear system' will refer to procedures that are aimed basically at maximizing the actual complaints or the observable symptoms of the individual patient and minimizing the effects of irrelevant subjective factors (e.g. third party claims).

The term 'objectivity', however, would basically refer to a value-free method and highly constructed forms that basically rely on independent testing indices.

A detailed acocunt of what we mean by 'objectivity' in general will be discussed as the chapter progresses.

The Medical Model: Value-Free or Value-Laden

The 'medical' or 'disease' model has gained its validity by the unique features of its research methods which centred around specific organic dysfunctions. The contribution of this model in disclosing many facts regarding the organic basis for many fatal diseases gives the medical model a very special status among other helping professions as reality-based and therefore highly objective. This has led many health professionals to apply the medical or biological model used in general medicine to psychiatry. This has meant that the principles and procedures which proved to be highly effective in dealing with organic cases are also employed in the diagnosis and treatment of psychiatric conditions (Guze, 1977).

Now, before criticising the application of the medical model to psychiatry as a necessary criterion for attaining a neutral perspective of mental illness, let us first examine the present limitations of the medical or disease model. A careful analysis of this model would reveal that in medical practice, the physician often bases his primary diagnosis of a given organic condition by relying on the patient's personal report. Consider, for example,

hypertension, asthma, epilepsy, etc., physical diseases which reveal themselves as altered functions, not structures. Thus, definition of disease almost always depends on the form of the altered function (e.g. weakness) rather than on the actual contribution of physio-chemical factors (Roth and Kroll, 1986).

In fact, most indications of physical disease involve the patient's subjective estimation of his disturbance as to whether he feels some sort of weakness, pain and suffering as the crucial symptoms of physical illness. The duration, area or location and severity of the pain and suffering are basically concluded from the patient's subjective construction of his perception and the doctor's personal judgement of the patient's pain starting point and how the patient responds to his illness (Ibid., 1986). Blood pressure and blood cholesterol, for example, vary largely from one society to another. Thus physical conditions have their idiosyncratic and relativistic aspects (Ausubel, 1974). In fact, cultural norms, values and social judgements play a considerable role in physical medicine. This is because the kind of societal norms and values influence the definition of the public's health concern, priorities of health services, and physicians' attitudes towards health in general. In Kuwaiti society, for example, people are very concerned with issues of fertility, and medical practice puts a great deal of emphasis on promoting fertility within the general population. In a different culture, such as Britain, for example, there is considerable concern about over-eating, obesity, drug-taking (Shaval, 1981). AIDS and venereal disease, on the other hand, are considered by some doctors

in Kuwait as reflecting the moral deficiency of the patient who is considered as irresponsible, bad and dirty. The present writer's communications with doctors in Britain has also revealed that some of them refuse to treat patients with AIDS. Some patients and prisoners who suffer from AIDS have been mistreated by hospital staff during their stay at the hospital or have been put in very isolated cells in prisons. This shows that the physician's concept of what constitutes appropriate procedures for dealing with a particular 'disease' might be heavily loaded with subjective values and personal moral orientations.

When the medical model is applied to psychiatry, the problem becomes even more complicated. This is because:

> "Theories about real physical disease are all about actual biological events which are generally agreed to impair function or shorten life."
> (Laing, 1983, p.41)

Thus, an application of the disease concept to psychiatry would be deceptive and confusing in that it promotes the meaning that the 'affected' individual has a specific defect which was caused by specific physiological dysfunction and that his problems can easily be diagnosed and cured. Thus, to use Laing's own words, "disease theory is not the best strategy to adopt" (Ibid., p.41).

A detailed analysis of the consequences of the application of the medical or physical model in psychiatry will be presented in the following pages.

3. The Validity of Internal Explanation in Psychiatry

> "We must abandon the medical model of human behaviour and allow psychiatry to die because the medical model does not fulfil our needs. Medicine is adequate for understanding human tissues but we need a model for understanding human issues."
> (Torrey, 1974, p.200)

The above quotation shows clearly the uncertainty among many health professionals towards the application of the medical model of internal causes to psychiatry. It is, however, debatable whether the best course of action would be to "allow psychiatry to die". It is true that a theory which accepts biological explanation as the basis for the diagnosis and treatment of psychiatric patients is bound to suffer from a number of fundamental limitations. The biggest problem is that psychiatrists are dealing with moods, feelings or "count qualities" (Laing, 1983). Moreover, as Laing points out:

> "We live by comparisons, similarities and dissimilarities, equivalents and differences which are forever devoid of objective content. We can never repeat an experience in the way we can an objective experiment."
> (Laing, 1983, p.12)

and

> "We cannot understand ourselves or others if we subtract our motives and intentions. But, objectively, there are no intentions. Objectively, an act becomes a thing.
> (Ibid., p.28)

Although Laing shows convincingly the subjective nature of psychiatric conditions which suggest and require a different context of research,

that does not mean that we need to lose sight of the need for a systematic and a reliable procedure for studying such conditions. In this connection, the present writer's proposal for the possibility of establishing a systematic approach for studying conditions described as mental illness will be discussed later on in this chapter.

Our main concern here is not with the organic or disease model in itself, but with the attempts of many psychiatrists to ground their interpretation of individual experience and subjective feelings by assuming that these are analogous to physical events and therefore easy to understand. The point which is being made here is that we have to allow for considerable differences between physical and mental illness. It is true that there are, as many psychiatrists claim, certain chemical and neurological changes associated with or cause some forms of mental illness. But that does not place mental illness on the same footing with medical disease. As Torrey (1974) puts it:

> "There are chemical and neurological components to all activities of the brain. Each thought, wish, memory or impulse has a chemical or neurological component. (p.39)

Such chemical components in themselves, however, are not in themselves sufficient for the interpretations of human thoughts and behaviour by analogy to organic dysfunction. The danger of making any sort of analogy between psychiatric interpretation and organic interpretation is that it reinforces the belief that it is:

> "... not necessary to demonstrate that a patient has a brain disease in order to gain credence for the claim of having discovered one; it is enough to postulate it and to claim that the 'chemical' method enables the specialist in mental disease to diagnose it."
> (Szasz, 1987, p.89)

When examining the 'clinical methods' used by mental health professionals, including psychiatrists, it becomes clear that such methods (e.g. classification, observation, psychological testing) are not fully adequate in providing sufficient information about organic dysfunction. In practice, "psychiatrists never touch their patients" (Torrey, 1974). Therefore, no claims concerning organic dysfunction in psychiatry could ordinarily be clinically grounded. However, the limitations of the disease model when applied to psychiatry should not prevent the researcher from trying to solve the problem of understanding the concept of mental illness. One of the central questions addressed by the researcher should be: what criteria need to be employed in order to formulate a value-free model of psychiatric definition of mental illness? and if we are unable to find any, we will have to face the question: must we formulate a value-free model? In the following pages we will try to examine some of the recent contributions in this area and show that some of these attempts have used the physical or disease model as a basic reference for obtaining a more neutral or objective conception of mental illness. We will argue that in the present state of knowledge in psychiatry, where there is a significant lack of biological correlation to the nature and content of the individual motivation and experience, the disease model is not a suitable account of conceptualising the individual psychological machinery.

4. Mental Illness as a Value-Free Concept

Most mental health professionals are fully aware that the symptoms of mental illness are to a large extent culturally specific. The very nature of the concept of mental illness, which is highly judgemental, promotive and normative, creates important limitations to the understanding and treatment of such conditions. Thus it would be extremely difficult, if not altogether impossible, to establish universally acceptable, value-free criteria for the conditions described as mental illness.

The problem is basically centred around the concept of mental illness itself. The very use of that concept would create an attitude and method of practice that is fundamentally puzzling and unspecific. That is because the language used by mental health professionals can build up and shape their perceptions and behaviour towards the methods of studying mental phenomena. That is to say that once mental health professionals use the term 'mental' they would as a necessary consequence assume that there is something wrong inside the patient's mind rather than outside him (see Sarbin, 1967). Thus, the very use of the term 'mental' would:

> "... not only constrain further descriptive elaborations of the conduct under observation, but also indirectly restrict alternatives to action."
> (Sarbin, 1967, p.447)

Although the above discussions suggest the considerable difficulties involved in conducting research in the concept of mental

illness along the lines of a value-free model, many writers have attempted this.

Lewis (1953) initiated these attempts by presenting the following criteria for the definition of mental illness:

1. The patient feels ill (subjective datum).
2. His functioning is deteriorating in some way (objective datum).
3. He has symptoms which follow a recognisable clinical pattern (topological datum).

For Lewis, the above criteria apply to both mental and physical disorders.

The efficiency of psychological functioning is decided by social criteria. For Lewis, social values and norms must not be introduced into any process of judging the presence or absence of mental illness because they imply disapproval and value judgements. Thus he states:

> "Deviant, maladapted, non-conformist behaviour is pathological if it is accompanied by a manifest disturbance of some such function ..., for illness to be inferred, disorder of function must be detectable at a discrete or differentiated level that is hardly conceivable when mental activity as a whole is taken as an irreducible datum. If non-conformity can be detected only in total behaviour, while all the particular psychological functions seem unimpaired, health will be presumed, not illness." (p.118)

The above quotation emphasises the importance of focusing on the person's total performance in any attempted definition of

the individual's presented problems, in the same way as in internal medicine where the disorder of any given function must be examined in the light of the total working of the body. Thus:

> "If the disturbance of part-function is without influence on his conduct, or falls within certain categories which we regard as 'normal', we do not infer 'mental illness' from their presence." (Lewis, 1953, p.114)

For that reason, Lewis excludes from the category of mental illness cases of psycho-neurotics, people with personality disorders or mentally defective individuals. This is because, although the above conditions might involve certain difficulties in adaptation and adjustment to social demands, due to bizarreness of impulse or character, it would be inappropriate to consider individuals with such problems as mentally ill in the absence of clear evidence of psychological disturbance. The question which needs to be addressed here is on what basis personality disorder can be distinguished from psychological disturbance. Simply on the basis of static state versus temporary or dynamic occurrence? If so, can Lewis defend this distinction? In fact, the concept of functional impairment for Lewis would surely include mental defect. The point is that functional impairment, unless otherwise specified could be congenital and static. Yet Lewis's criterion of psychological disturbance as distinct from personality disorder (psychopathy) seemed to require a dynamic (temporary) occurrence. This split did not fit.

Lewis points out that it is very difficult, if not impossible, to develop a practical method for the identification of impulse

dysfunction or psychological dysfunction. However, he suggests that in an analogy to the 'biological disadvantage' which may be taken as an indication of 'physical dysfunction', social maladaptation or non-conformity under certain circumstances and statistical frequency may be taken as positive criteria for the presence of 'psychological dysfunction' which can be applied to personality disorders. Lewis's claim of the "adequacy of adaptation" criterion must be intended as objective. Thus, according to Lewis, a condition can be considered as a personality or pathological disorder only if there is a significant disturbance in thinking (such as delusions) or perceptions (hallucinations) or in the emotional state (anxiety). Such disturbance would deviate from the ideal social expectations and has statistical frequency alongside pre-morbid personality development. Moreover, Lewis suggests that the designation of a case as one of mental illness could be based on the individual's intrinsic subjective distress.

A careful analysis of the argument put forward by Lewis would reveal the following points: firstly, Lewis believes that the concept of mental illness and mental functions in general might be understood if we accept the medical interpretation of how biological disadvantage might be caused by 'physical dysfunction , as offering a valuable criterion in this respect (see Schwab and Schwab, 1978, p.121).

Secondly, Lewis is prepared to define a person as mentally ill on the basis of 'recognisable medical patterns' as well as his intrinsic suffering but not on the basis of an interaction between

the individual and his social environment. The question which needs to be addressed here concerns what can be considered as 'recognisable medical patterns'. Finally, although Lewis rejects social norms as a criterion for determining the presence of mental illness, he does, however, accept social norms as an important factor in the estimation of the 'efficiency' of psychological functions. In practice, it seems, however, that accepting social values as an evaluation factor for the efficiency of psychological functioning will inevitably lead the clinician to base his diagnosis on value judgements, in terms of, for example, the kind of social elements that count as effective for the estimation of psychological efficiency.

A further attempt to develop a definition of mental illness has been made by Spitzer and Endicott (in Spitzer and Klein (eds.), 1978).

Spitzer and Endicott conceptualise mental illness merely as a subset of medical disorder, best conceived of as a generalised impairment in the functioning of the individual. However, they do not specify what functions of the individual need to be disturbed for the disorder to be identified as mental illness. It is true that they emphasise that "a wide range of activities need to be affected if one is to avoid an a priori decision as to what areas of human activity are basic or essential" (p.23). It could, however, be argued that specifying what areas of functioning need to be disturbed would be more productive than leaving the clinician to consider every aspect of behaviour as 'essential' or 'basic' functioning. In this case,

even going for a walk in the street might be viewed as a basic disturbance in the individual's cognitive functioning which has led him to 'wander away'. Furthermore, there is a difference between crude references to aversion and a reasoned and defined account of certain brain mental function suggested by (though not elaborated in) Boorse (1976), as we shall see shortly. Spitzer and Endicott try to solve the above problem by stating that a function would be considered to be a sign of illness if it causes 'subjective distress', 'disability' or 'disadvantage' in dealing with some aspect of the physical or social environment. The question which Spitzer and his colleagues do not answer is: What if the individual manages despite his 'disability' or 'distress' to live within the standards of his society (even though his behaviour might not be fully accepted by this society)? Another related question is how many of these three elements must be present in order to be able to define an individual as mentally ill. In actual practice, "it is easy to judge them so that one or more (of these criteria) are present or absent, as the classifier desires" (Szasz, 1987, p.55). Moreover, Szasz goes on to argue, when considering the three elements specified by Spitzer as essential for the identification of mental illness, that the psychologist can "attribute distress to anything he wants to: for example, he may infer distress from smoking and not being able to stop, or from being able to stop but wishing to smoke" (p.55).

If we consider a second criterion, 'disadvantage', Spitzer claims that being disadvantaged must be the result of 'distress' and 'disability'. Accordingly, a single Kuwaiti woman who has an

affair with a man would be considered to be in a 'disadvantaged position'. That is because such behaviour would be condemned as extremely immoral in Kuwaiti society. Or, as Moore, puts it:

> "If one were to keep extending such examples, one would include all seriously immoral or illegal acts as leading to painful consequences in all cultures and thus to disadvantage and all dispositions to such activities as medical disorders."
> (Moore, 1984, pp.213-214)

Thus Spitzer would presumably be content to place the above-mentioned case in the category of mental disorder even if the woman in question does not show any signs of 'distress', 'disability' or 'disadvantage'. This would be because for Spitzer she would be vulnerable to 'disorder'. As mentioned in previous chapters, being in a vulnerable condition implies the presence of an inherent unspecified genetic 'weakness' which interacts with stressful events in the person's life and which eventually produces disease. Such a view of vulnerability presupposes the theory of a 'residual' disease with a permanent vulnerability to a different attack in the future (Zabin and Spring, 1977). As a result, Spitzer has created a special category in DSM-III to accommodate such cases. This criterion incorporates "conditions not attributable to a known mental disorder" (Spitzer and Endicott, 1978, p.31).

In addition, if the Kuwaiti woman's 'pathological' relationship with her lover responds well to 'technical intervention', (presumably psychotherapy or medication or indeed punitive sanctions),

then such a response is taken by Spitzer to show that we are dealing with an 'abnormal' case. It is obvious that such an assumption does not stand up to close scrutiny. The fact that 5 mg. of Mogadon could help a person who has not slept for two days, does not make temporary sleep disturbance a 'disease'. One could cite many such examples to refute Spitzer's claims.

The medical terminology used by Spitzer, such as 'clinical intervention' or 'clinically significant' symptoms carries with it the basic assumption held by Spitzer and his colleagues in the APA task force for DSM-III, namely that "mental disorder should be defined as merely a subset of medical disorder with primarily behavioural manifestations" (p.16). However, Spitzer himself admits that "most of the mental disorders represent syndromes rather than disease since rarely is the etiology or underlying process known" (p.29). Though of course being unable to classify a condition as a 'disease' does not mean it is not a medical disorder.

In conclusion, Spitzer and Endicott's attempts to establish a definition and a set of criteria for the diagnosis of mental disorder, based on the medical model and universally applicable, is simply not convincing. The writers' desire to establish a 'scientific' and 'objective' value-free model of mental disorder confines them to the methods used in physical medicine (e.g. diagnosis, classification, prognosis, independent testing procedures, etc.) that are basically oriented and designed to discover certain organic failure inside the body rather than to detect the subjective experience, for example

> "... the successful application of the criteria for medical disorder to that subset termed 'mental disorders' demonstrates the appropriateness of the medical model as applied to mental disorders."
> (Spitzer and Endicott, 1978, p.38)

The use of these methods in physical medicine does not necessarily entail that similar methods will work when applied to psychiatric conditions. That is because when evaluating any psychiatric condition, the evaluator needs to measure the 'patient's' personal traits. The tests which are used by the psychologist, for example, could be a personality (such as M.M.P.I.) or I.Q. test. The scores on both kinds of test must be interpreted according to certain 'healthy' norms of adjustment. A healthy score must show how the individual's total behaviour deviates from the requirements of adequate 'normal' functioning within a specific social system. The problem with such procedures is that they are basically related to the psychiatrist's view of what constitutes normal functioning or proper adjustment to society. But clearly, such procedures are not independent from the patient's unique past history, his social context, and the familial or work environment. Furthermore, establishing a final diagnosis in psychiatry is an endeavour that cannot be divorced from the psychiatrist's personal view of what constitutes proper adjustment and the society's general definition of mental health norms. Perhaps the following quotation from Scott (1971) would explain how the lack of appropriate testing methods in psychiatry which are independent from the observers or the society's norms might cause many methodological and definitional problems:

> "If the stability of the larger social system be regarded as the final good, or if human development be seen as demanding harmony in relation to that social system, then such an assumption would appear basic and defensible. But one is still impelled to consider the possibility that the social system, or even an entire society, may be sick, and conformity to its norms would constitute mental illness in some more absolute sense." (p.19)

The above discussion of the lack of independent testing procedures in the mental health profession does not undermine the importance of such methods. Psychological phenomena cannot be reliably examined without the use of methods that are contextually dependent and based on subjective mutual agreement between the psychiatrist and the patient, i.e. agreements on the significance of life events that are related to his present problem. Thus one is compelled:

> "... not to talk about a 'case' in psychiatry - rather we try to assess functional impairment in specific situations as viewed by different professional groups in the community." (Lindemann in Scott, 1971, p.9)

It must be re-emphasised that establishing a 'diagnosis' in psychiatry must be the result of a professional definition as well as the patient's personal account. However, it must be acknowledged that Spitzer and Endicott have made a major contribution to the understanding of the importance of 'subjective' distress (that acknowledged by the individual himself) and 'disability' (which implies an impediment in "functioning in a wide range of activities" (Ibid., p.23) in differentiating between 'disorder' and 'normality'. For them it is necessary to distinguish between intrinsic distress, when the individual

recognises his suffering and the need for professional help on the on hand, and the 'illness' label which can be applied to the social misfit or non-conformist and which does not necessarily, though of course may, indicate subjective distress, for example, the recognition of homosexuality.

Peter Sedgwick in Edwards (1982) take a different stance on the possibility of establishing value-free methods in psychiatry. For him "there are no illnesses or diseases in nature" (p.50) but happenings or incidents which occur before the construction of the human social meaning, to which, later, people ascribe their own social meaning by labelling them as disease. Thus, illness and disease criteria represent nothing but an arbitrary social evaluation. The definitional process of illness, Sedgwick maintains, begin when, first there are natural events or, second, there is a specific functional failure that is intelligible when considered within certain norms or values that are held by a given society. Thus:

> "An attribution of illness always proceeds from the computation of a gap between presented behaviour (or feeling) and some social norm. In practice, of course, we take the norm for granted, so that a broken arm would be no more of an illness than a broken fingernail unless it stopped us from achieving certain socially constructed goals." (p.54)

Thus the definition of bodily illness is only a mirror of the insignificant or under-valued phenomena. Consequently, the clinician needs to 'medicalise' moral values rather than illness <u>per se</u>. Sedgwick

presents the following example to illustrate the above position:

> "The blight that strikes at corn or potatoes is a human intervention, for if man wished to cultivate parasites (rather than potatoes or corn) there would be no 'blight' but simply the necessary foddering of the parasite crop." (p.50)

Accordingly, one can invoke:

> "... a unitary perspective on physical and mental illness so long as a common structure of valuation and explanation applies over the whole range of disorder of the person." (p.55)

According to the 'whole range of disorder of the person' or the 'whole individual' criteria, mental illness would be viewed by Sedgwick as falling within the disease or body state medicine and not as something different from physical medicine. In his article, Sedgwick has used the concept of disease and illness interchangeably. That is because he has already merged the terms 'disease' and 'illness'. For him both conditions represent a human invention.

Sedgwick's position is very similar to that taken by Kendell (1975) when he claims that mental illness meets the same criteria of physical illness, i.e. increased mortality, reduced fertility, etc. As a result, Kendell argues, mental illness is merely an expression of physical illness.

By now, it has become obvious that Sedgwick subsumes mental and physical conditions together (as evaluative conditions).

Sedgwick's contribution to the role of social judgement in labelling a condition as 'disease' or illness is significant in that it highlights the subjective factors (e.g. cultural norms) involved in the designation of human conditions as 'disease'. It is, however, rather difficult - in relation to some clear-cut organic cases - to establish clearly the role of socio-cultural norms in labelling physical conditions as 'disease'. To do so with respect to certain psychiatric conditions seems to be a great deal easier. Consider, for example, the act of suicide. In traditional Japanese culture, the Samurai who commits suicide is considered to have done the honourable thing. In Kuwait, however, a person who commits suicide is viewed as 'unmuslim' and mentally disturbed because he has violated the Quran and the will of Allah for which he will go to hell. For that reason, very few individuals in Kuwait commit suicide. In addition, most of the Kuwaiti Bedouin women who suffer from depression, complain mainly of the somatic condition (headache, sleep disorder, lack of appetite) and ignore or deny the emotional aspect of their problem. A simple explanation for this situation is that women in Kuwait are not expected to complain because complaints of an emotional nature are considered as a sign of inefficiency or an inability to cope with familial duties or even as an indication of psychiatric disorder. To take the comparison even further, if a British person claims that the MI5 are watching him through the screen of his T.V., he would be a plausible subject for psychiatric intervention, whereas a primitive African who believes in magic power would be considered normal. Similarly, acts of self-mutilation can sometimes be a fully accepted part of a particular cultural context and as such, perfectly normal behaviour.

Thus, certain psychiatric conditions can be seen as 'manufactured' by the social value meaning people attach to them. However, for Sedgwick, both physical and mental illness imply an awareness and understanding of what is supposed to be an alternative, preferable state of norms and values. In the absence of such values or 'normative alternative', the presence of lesions or subjective feelings will not necessarily lead to the labelling of certain conditions as 'illness'. Accordingly, psychiatry and physical medicine resemble each other in that their definition includes the identification of norms and values. Therefore,

> "... mental illness can be conceptualised just as easily within the disease framework as physical maladies such as lumbago or T.B." (p.56)

Thus Sedgwick draws our attention to the fact that both physical and mental illness can be seen as a valid reflection of social value judgement, and that they both represent an arbitrary, socially-received label. This is because both physicians and psychiatrists are conditioned by social norms and values in their evaluation of the significance of 'illness' or 'disease'. One problem with this argument, however, is that it ignores the fact that - with respect to certain well-established medical conditions - the judgemental accuracy and degree of reliability of physical conditions is still a great deal more obvious than in the case of psychiatric conditions which are not totally free from values. Moreover, Sedgwick provides little evidence for his contention that there is a common structure of valuation and explanation for medical and physical illness. Furthermore,

Sedgwick does not take into account the meaning or the significance of illness for the 'ill' individual and how illness influences his career (Treacher and Baruch, 1981).

Finally, Boorse in Edwards (1982) proposes a distinction between the terms 'disease' and 'illness'. For him a 'disease' is 'an internal state' which represents either an impairment in normal functional ability below typical efficiency, or else, an impairment caused by 'environmental agents'. Accordingly, 'disease' represents a 'biological fact' since the 'functional organisation' typical of the species is 'value-free' (p.30). And since the concept of mental illness is heavily loaded with society's moral and social values, it would be more appropriate to explore the concept of 'mental disease' rather than that of 'mental illness'. Disease, Boorse maintains, becomes an illness only if it is serious enough to be incapacitating and therefore undesirable and meriting special treatment. The problem with mental illness, Boorse argues, is that it is difficult to define in terms of biological facts, because feelings, beliefs and experience or mental causations need also to be considered in the definition of the concept. Mental disease, on the other hand, must be characterised in terms of functional dysfunction and must be understood on the same principle as disease in physical medicine, in that both mental and biological dysfunction could cause survival and reproduction problems (in this, Boorse clearly adopts Kendall's position).

Moreover, the concept of a functional state and a mental causal process are in an early and undeveloped state similar to the

beginnings of early physical medicine. The development of the idea of mental functions could take a similar course to that of biological functions in physical medicine. That, however, does not mean, Boorse argues, that mental functioning is determined by physiological functioning. The causal laws of mental function are not reducible to causal laws of neural function. Thus, for Boorse:

> "If the mentalistic vocabulary is not neurologically definable, there will be no way to reduce the causal laws of the mind to the causal laws of the body. If so, the distinction between conditions that receive one kind of causal explanation and those that receive the other may be a permanent one, justifying an autonomous science of mental health." (p.34)

The above quotation shows that Boorse is completely rejecting the identity or design theory (which views mental function as manifestations of brain events). But Boorse does not deny at the same time, the need for some sort of analogy between mental functions and physical or neural functions.

Boorse justifies his position that mental events do not necessarily equal neural events by the following example:

> "Not the desire for a lobster dinner, but Smith's desire for a lobster dinner as felt between 4 and 5 pm on 13th February 1975, is claimed to be identical to his being in some neural configuration during this period. The distinction is crucial, for if types of mental states are defined by their functional properties, type-type identify statements are unlikely to hold. If Smith's current neural state is a desire for a lobster dinner, that is probably not because of any anatomical

> feature, such as its containing a lobster-shaped nerve net. Rather, on the view we are considering, it is because of the motivational role this state plays in producing a search for a seafood restaurant or other lobster-obtaining behaviour." (p.33)

Accordingly, given 'motivational' roles (motivation to function in certain ways) might be caused by different neural systems in different people. Therefore, the basic characteristic of mental disease is mental causation which is not equal to physical events or neural causation.

A crucial point against Boorse is his view that unspecified mental dysfunction should be studied in the same way as medical dysfunction, as if the limits and the degree of mental dysfunction are well-established, while he suggests Freud's psycho-analytical theory as the best available approach to the study of 'inner' mental life.

For Freud, inner mental functions could be examined or revealed throughout the analysis of dream content, insight or self-knowledge, hypnosis, active listening, unconscious forces, transference, interpretation, etc. (see Bloch, 1982, and Hartmann, 1973). The psycho-analytical view of mental functions or mental system (e g_O, id, superego) is largely based on Freud's medical training which led him to use the functional concept in physiology and applied it in studying the mental system (see Hartmann, 1973). The only difference between Freud's 'mental functions' and 'functions' in general physiology is that the former is largely or totally derived from subjective and unverified testing procedures. Functions in general physiology,

however, can have realities that are largely independent from the observer. The problem is that Freud created such mental functions rather than discovering them (see Skinner, 1973).

The crucial question is, how do we accurately detect the disturbance in Freudian mental functions? For the psychoanalysis school, meta-psychological investigations are appropriate for identifying mental functions. That led psychoanalysis to consider the unconscious system as a proper area of examination. Their methods of examination would undoubtedly be based on a comparison between the analyst's insight and the patient's reality-testing. What if both concepts of the problem contradict each other? (see Hartmann, 1973). Freud and his followers escape the above dilemma by claiming that their 'patient's' mental functions have some sort of 'actual unreality' and must be transformed into "physical reality" - presumably the reality of the analyst (for more details see Szasz in his article "The Lying Truths of Psychiatry", (1979).

B.F. Skinner (1973) provides an excellent conclusion of the present status of the psychoanalytical view on inner mental functions:

> "Human behaviour is in a state of flux and undergoing changes that we call "processes", but what is changing in what direction when we speak of, for example, an effective process? Psychological "organization", "mental system", "motivational interaction" - these all imply arrangements, or relationships among things, but what are the things so related or arranged? Until this question has been answered the problem of the dimensions of the mental apparatus can scarcely be approached." (p.190)

Indeed the psychoanalytical model lacks a clear or accurate methodological procedure to determine mental functional norms. It seems that even in the future, it would be illogical to assume that a systematic account of the definition of mental functions could be attained through the analysis of the patient's past experience or unresolved inner conflicts. Although one cannot deny the importance of the individual's past experience in the identification of his mental functions, such experience provides the clinician from any school of psychology with a causal link between the patient's symptoms and previous psychological events. The only problem with the psychoanalytical school is that they have placed a causal link on the unconscious level which implies a 'psychic determinism' (see Bloch, 1982). As a result, no matter how the patient behaves, there are always sexual or aggressive impulses which are always considered to be 'irrational' hidden in the 'id' or unconscious system. How then would a value-free model of 'rational' or 'irrational' repressed experiences or desires be attained? (see Lavin, 1985).

Clearly, therefore, the psychoanalytical approach cannot yield objective mental function in the sense which Boorse's account requires.

Boorse escapes the conflicting moral issues which are centred around the concept of mental 'illness' by restricting his argument on the distinction between mental 'illness' and mental 'disease' with special emphasis on the 'disease' concept (Ibid., 1985). His model is clearly built on the strengths of the medical or physical

model. That is to say that Boorse implicitly analogises from a disease in the biological system of the body (such as the heart), to a disorder of the mental functioning.

Mental processes can be examined, Boorse maintains, not by observable behaviourable disturbance, but through the psychoanalytical approach which is best suited to account for internal malfunctioning. (The psychoanalytical model was also criticised in Chapter three, see Skinner in Moore, 1984, and Skinner, 1953.)

Now, even if we accept that mental processes can be 'species-uniform' does that mean that such processes are independent of contextual effects? Boorse does not provide us with an adequate answer to this question. A further important question is how the 'inner mental process' might contribute to the establishment of a context-free model in psychiatry? Boorse provides no sufficient answer for the above question. That is because he does not provide us with an organised systematic science of inner mental functions and dysfunctions.

One might be tempted to agree with Boorse when he states that:

> "Deviance from every considerable standard is not a necessary condition for mental disorder." (p.39)

Yet deviation from a social or residual rule is a central criterion in deciding the normality of any given individual, whether mental health professionals like it or not. Moreover, professional judgement

of whether any particular mental process or function is appropriate or inappropriate raises many questions regarding the validity of using 'objective' methods in the definition of mental disease. The question which needs to be addressed here, is whether Boorse's 'objective' mental functions are identifiable. In fact, Boorse has given us a provisional conditional thesis, not yet a categorical one. The medical model might still have something to be said in its favour. We might, for example, be able to distinguish mental causes or aetiology for different forms of behaviour for instance. Boorse, however, does not provide such an account.

What Should a Value-Free Model of Mental Illness Be? A Proposed View from the RFD

By now it has become clear that attempts to establish a value-free or objective method for the study of mental illness have mainly been built on the strength and validity of the biological model (Lewis, 1953; Spitzer and Endicott, 1978; Boorse, 1982; Klein, 1978). It has also become clear that neither the psychoanalytical approach nor the medical model can be productive in resolving the problem of objectivity in the evaluation of mental illness. This is because of the complexity of psycho-social factors with which the clinician has to deal in psychiatric practice, for example, the etiological significance of past events, traumatic experiences in early life, etc. The 'inner' explanation of mental dysfunction conceptualises the mental activity of the individual in the same way that the biologist conceptualises physiological function, i.e. as

predetermined. Thus there is no room for individual uniqueness or for the individual's ability to contemplate himself and his actions or for the individual's ability to evaluate his past experience and to exercise control over his future. Again this depends on how specific mental functions turn out to be.

Alternatively, if we accept the argument that mental dysfunction must be understood in terms of biological dysfunction, or that there are identifiable brain mechanisms for such functions, we have to bear in mind that the design of psychiatric treatment is crucially different from the standards that applied in physical therapy. In psychiatric practice, the therapeutic efforts are basically oriented to control the symptoms (reduction of anxiety, for example) and psychotherapeutic methods such as rational-emotive therapy or behaviour modification or client-centered therapy or family counselling are directed towards improving personal effectiveness and social adaptation. However, such goals are closely tied up with the individual's basic, cultural norms and values. (For more detail on the psychiatric models of illness and their treatment approaches, see Alanen, 1984.) In Kuwait, for example, the high value goal of psychiatric treatment is the removal of undesirable symptoms. In Britain, on the other hand, helping an individual to gain insight has a higher value, while attitudes to psychiatric practice in a country like the Soviet Union are rapidly changing. Therefore, it would be difficult if not impossible to believe that physical and psychiatric methods of interpretation are similar, or that most cases of mental disorder, especially neurosis, can be detected within certain recognisable clinical patterns. Mental

illness or disorder, however, can be identified only in relation to therapeutic goals in different cultures, so that there can be no mental disease of the type Boorse proposes, i.e. there cannot be mental functions which are objectively disturbed. In reality, there is the danger of a loss of insight when the concept of mental illness is conceptualised in analogy to inner biological dysfunction. What mental health professionals are often diagnosing and treating in the everyday practice are values and subjective suffering that do not have any sort of analogy to physiological dysfunction. Committing suicide as a result of a broken marriage is crucially different from committing suicide as a result of an infection of the central nervous system by the HIV virus in an AIDS patient which would eventually affect his rationality. Surely the former case needs a different kind of interpretation from that of the latter one. Or as Laing puts it convincingly:

> "Psychiatry tries to be as scientific, impersonal and objective as possible towards what is most personal and subjective. The disordered sleeping treated by the psychiatrist has to do with what are our most personal and private thoughts and desires."
> (Laing, 1965, p.146)

Thus, an abnormal mental state when examined in terms of objectivity or in analogy with 'pathological inner agents' appears as unintelligible (Bandura, 1974). But, it may be objected, such 'pathological inner agents' may yet be discovered - some have been. Our classification of mental states do not currently reflect this kind of aetiology (still in the descriptive level). Our classifications and definition

of mental inner states would presumably have to be redistributed if such inner agents were discovered. But this does not make the disease dysfunction hypothesis completely 'unintelligible'. Perhaps biological or inner 'disease' agents could explain the 'content' of many mental dysfunctions such as: thoughts, intentions, beliefs, motives, emotions, reasoning, etc.

In response to this argument, the validity of "inner" pathological agents cannot be attained from the application of methods that are used in the 'disease' model in general medicine. If future neurological research could establish a clear-cut evidence of causal contribution of inner mental states, we should be clear about the intelligible scope of such causal mechanisms. That is to say that even a clear physiological evidence of inner psychological conditions is not sufficient to provide a convincing account of the unique content of any psychiatric condition. It might, however, suggest certain neurological contribution to the frame of the psychic condition. In fact:

> "... one could not suggest a general type of neurophysiological correlate for phobias of carts or for compulsions to wash one's hands, but one could suggest a type of organic cause for phobia in general or for compulsion in general, allowing that what a phobia is of or what a compulsion is to do is not a matter of physiology. But one need not suggest this, for one could hold that even phobias and compulsions in general have no physiological disorders in common to them, and are thus purely functional."
> (Stevenson, 1977, p.40)

This leads us to conclude that the problem is basically related to confining a physicalist interpretation to physiological conditions and extending such interpretations to psychological conditions as well. The extension of physiological interpretation to subjective psychological states would be illogical "... since the terms have different truth conditions and implications" (Clarke, 1980, p.160).

A simple reply to the writers who try to reduce the individual psychological functional disturbance to biological inner agents is that one needs to develop precise criteria for the identification of mental illness before any reductionist attempt. "We must have criteria for distinguishing the mentally ill from the merely unusual or disfavoured" (Stevenson, 1977, p.40).

At the present time we do not seem obliged to consider the notion that mental inner states are meaningfully correlated with the norms of explanations or interpretations that are used in the medical model, as representing anything better than a logical error. At the present state of our knowledge, mental causation seems meaningless and unintelligible when conceptualised within the biological model. Labels are important because they lead to certain implications and connotations which shape the attitudes and behaviour of the professionals in charge. Thus, the disease model, as Bandura (1974) believes, is:

> "... misleading because there are no infected organs or psychic disease entities that can be identified as causal agents. The psychic conditions that are assumed to underline behavioural malfunctioning are merely an abstraction from the behaviour." (p.70)

Bandura's argument is convincing in respect to many psychiatric dysfunctions like, for example, compulsion, phobia, anxiety state, etc. Perhaps at a sufficiently general level, mental functional disturbances will resist being dismissed like this. However, this requires a great deal of philosophical clarification that has yet to be carried out.

Now, is there a possibility of having a value-free model of mental illness?

In answering this question, let us for a moment recall what we previously mentioned about cases such as Mr. M, who was raped at the age of 8 and then developed different forms of obsessive anxiety reactions towards his eating behaviour, fear of being infected by AIDS or of having run someone over on the road, etc. Cases such as Mr. M or Mr. D's spending behaviour and many other cases would be a good illustration of the way the medical or disease analogy of mental illness is applied and the consequences of such application.

Now, let us imagine a hypothetical situation where Mr. M is arrested by the police one evening while searching for the body of the person he imagined he had run over. During the investigation procedures conducted by the police, Mr. M admits to his fears and

the police eventually refer him to the mental hospital for a decision on whether he is mentally disturbed or not. If Mr. M were to be examined by a psychiatrist who held the same views as Lewis for example, he would undoubtedly state that Mr. M had symptoms which conform to a "recognisable clinical pattern" and which were the expression of a partial disturbance in his physio-psychological function. Someone like Spitzer, on the other hand, might offer two solutions: either the patient is distressed, suffers from a disability and is thus in a disadvantaged state characterised by a generalised impairment in his major functions. Or, even if the patient did not show distress and disability at the time of investigation, he could nevertheless, be affected by the disease in time to come.

The position of someone with Sedgwick's views would maintain that Mr. M's mental disturbance is no more than an arbitrary social evaluation or human invention. But how useful such principles are for the screening of mental illness is a question to which a psychiatrist of this particular school of thought has no answer.

A psychiatrist persuaded by the views of Boorse, on the other hand, might view the patient's mental dysfunction as something that could cause survival and reproduction problems, therefore Mr. M's mental problem should be examined within the same methods of physical disease. For that purpose, Boorse suggests, psychoanalysis as the best alternative to study the patient's inner mental functions. (Boorse's main thesis here is that all diseases have comparable underlying descriptions and physical disease is only one subset of disease.)

The above discussion leads us to the conclusion that it is difficult, if not altogether impossible, to establish a definition of the patient's subjective unusual experience in "nomologic form" (Max Weber in Schwartz and Wiggins, 1987). Such a universal or 'independent' check on the individual's experience can only be understood, in Max Weber's term, in "an ideographic form". That is because of the particularity and the uniqueness of the 'truth' of the person (Gorovitz and MacIntyre in Runions, 1984).

It must be emphasised that 'clinical' psychiatric judgement is not directed or referred to the patient's mental dysfunction, but as Gove (1982) argues correctly, such clinical rationale is basically established on the patient's overt behaviour. Thus, the illness is the behaviour. Such criticism of "inner mental dysfunction" does not discredit the search for a stipulative and clear conceptual analysis of mental illness. What mental health professionals need is to be fully aware of the consideration or the process that led them to define a person as mentally ill, and of the importance of the fact that they are dealing with a person who <u>has</u> some sort of disorder, not someone who <u>is</u> 'disordered'. Thus the totality of the person's psycho-social dimension of his suffering as conceived by himself must be considered as a central element in any psychiatric clinical judgement.

Pushing the argument further, let us imagine (what in fact is true for many Kuwaiti psychiatric patients), that Mr. M had actually come to terms with his suffering and pain because he considers his

condition as a sign that God loves him and has selected him among many others to test his acceptance of God's will. Thus, the Quran states that:

> "Never is a believer stricken with discomfort, hardship, illness, grief or mental worry that his sins are not expiated for him."

Thus, for Mr. M and many other individuals who experience mental anguish, suffering is an opportunity to face misfortune with patience - this being a favourable act towards God who tests a person's patience as a sign of faith.

Now, how could a value-free model of mental illness be established that is capable of judging Mr. M in Kuwait as well as a Mr. M in Britain with the same degree of objectivity and reliability? Boorse, for example, evades such questions by sidestepping the conceptual and moral problems attached to the concept of mental illness. Instead, he tries to show how mental functions can be evaluated and understood in a relatively similar method to function in the physical state.

If one considered that the 'disease' model when applied in psychiatry might not create insuperable conceptual and practical difficulties, Boorse's distinction between illness and disease could offer a suitable account. But Boorse's account can be extended from physical disease to mental disease only if we give an 'independent' account of mental functions and this Boorse fails to do, as he envisages the psycho-analytical approach as a representative for his model.

Such a model (the psycho-analysis) is already value-laden as discussed previously.

Spitzer, on the other hand, solves the problem by providing us with vague terms such as vulnerability, unspecified mental disorder, etc. Sedgwick's system of evaluation claims applicability to both physical and mental illness, but does not give any useful insights of how such a system can be applied in reality.

Thus, one is compelled to question the possibility of applying one exclusive approach of 'objectivity' or 'neutrality' in dealing with such a complex and controversial concept as mental illness. What in fact is needed in any discussion of the concept is to examine the possibility of:

1. establishing independent functional activities that are unrelated to the structure of interpretation used in physical medicine (Eysenck, 1969);
2. using a systematic method that is specifically designed and appropriate to accommodate the complexity of mental phenomena, i.e. without requiring interpretation via some set of values or other;
3. adopting a systematic pattern in the identification of some of the central features of psychiatric disturbance which takes the following into account:
   - the individual's call for specialised help;
   - the reasons and motivational patterns that the individual himself attaches to his actions (Moore, 1984);

- a special insight into the factors which determine the evaluative content of psychiatric definition;
- examining the possibility of having a relatively systematic view of mental illness within a context-dependent approach.

The points listed above will be discussed in considerable detail throughout the rest of this chapter.

How the RFD Conceptualises the Possibility of a Context-Independent Approach to Mental Illness

Now it is necessary to discuss the RFD proposal as an alternative view of mental illness which takes into consideration the limitations that are previously mentioned. For the sake of argument, let us recall in short what we previously mentioned about the basic features on RFD approach. For an individual to be diagnosed as suffering from RFD, he must be in a state where there is a temporary 'total' functional failure on the integration level on both the physiological and psycho-social function and this failure must be the result of external rather than internal biological reactive process.

The RFD model places a central emphasis upon the importance of the individual's total rather than partial functional failure.

Moreover, a crucial element in any definition of the adequacy of the individual's psycho-social functioning is his motivational and cognitive system that underlies such functions.

One of the basic criteria, mental health professionals use in judging the normality of any given individual is whether his actions are motivated or not, or the degree of plausibility or intelligibility of his motivations. Another central scale which is relevant to the motivational criteria is the nature of judgement, understanding, insight, the degree of awareness and perception which the individuals attach to his behaviour and which constitutes his cognitive system.

Champlin in Brecher (1987) provides us with a very good illustration of the above argument by stating that:

> "Wild, far-fetched or absurd suspicions do not of themselves guarantee mental illness; but the situation changes if they are so senseless that they have to be seen as insane suspicions. Extreme, unprovoked violence is not by itself enough to betoken the psychopath; his behaviour has to be seen as insanely violent. He throttles the man in front of him in the queue at the bus-stop. When asked to explain, he says "The bus was coming and it was nearly full. I was fed up with waiting in the cold so I told the man in front to step aside. He refused so I pushed past. He resisted and we began to fight; as the bus approached I squeezed his throat until he stopped struggling. Then I got on the bus."
>
> An insane degree of violence was used, given the object achieved. I think that if he was in the habit of resorting coldly to such extreme, unprovoked, pointless violence, he could not but be mentally ill." (p.64)

Thus, it is crucial, in this respect, to analyse what kind of motive or reasoning the individual attaches to his disturbance. Research findings cited in Taylor and Brown (1988) show clearly that people in a depressive state, with low self-esteem, have a more balanced

and realistic evaluation of their present and future life. 'Normal people', on the other hand, may possess an unrealistically positive view of themselves and an exaggerated belief in their ability to control their environment as well as an over-optimistic view of the future.

Clearly, any analysis of the motivational and cognitive context of an individual's major functioning would reflect the individual's unique experience, his methods of interpretation of life events, the nature of his disturbance and the reasons he attaches to his actions. Unfortunately, many health professionals do not consider the motivational and cognitive dimension underlying the disturbed function as a meaningful and valid interpretation of the individual's total personality or his subjective needs. This is because the nature and content of personal motivation, meaning and cognitive process is extremely complex and thus vulnerable to many different contextual influences. The clinician, therefore, finds himself in a situation where the traditional methods of understanding and interpretation are not entirely adequate and contextual influences, e.g. occupying the role of a patient and the disturbance of his previous social role, being in a mental hospital, the clinician's personal system of interpretation, etc., eventually outweigh the individual's personal motives and reasons. (For more detail, see Rosenhan, 1975.) Thus to see symptoms, i.e. bizarre thoughts:

> "... is not to see neutrally ... We cannot help but to see the person in one way or other and place our constructions and interpretations on

> his behaviour, as soon as we are in a relationship with him."
> (Laing, 1960, p.32)

The point Laing is making here is that individuals are very obviously bound by context. Function "occurs against background, but this background is not something neutral; rather it is also to be taken under intentional description" (Pinckard, 1976, p.167). What is more, motives and functions are purposefully related even when certain kinds of function appear as if irrational or unmotivated and hence deviant (consider Mr. D's spending behaviour, for example).

Thus, there is a crucial difference between saying that X is a schizophrenic and saying that X is motivated to behave in a certain way. The first instance is a case of labelling which does not really explain what is wrong with X. In the second example we are analysing the motivation behind the function, something which might help make the patient's private suffering more accessible to the clinician's understanding. After several attacks, for example, most schizophrenic patients develop a certain pattern of motivation in terms of coping strategies which are crucial in protecting the patient from further relapses. Most schizophrenics learn after several attacks to come to terms with their suffering and a degree of withdrawal, as well as with the nature of thoughts and language that might cause misinterpretation of the patient's cognitive behaviour. Such coping tactics are largely linked to the cultural or societal conception of mental illness (Townsend, 1978).

Thus, the individual's interpretation of his methods of functioning and how they relate to his motivation and his cognitive system is very important for the design of viable methods of studying the individual's malfunctioning.

Now what can an awareness of the motivational-cognitive dimension of individual functioning contribute to the design of an appropriate method for defining mental illness? Or, to put it in another way, how can we assess the individual in a way that acknowledges the influence upon him of his context?

Before answering the above questions, it is necessary to define in detail what we mean by 'objectivity' in general. The definition of 'objectivity' as is stated in Blackiston's Gould Medical Dictionary (fourth edition):

> "... pertaining to an object or to that which is contemplated or perceived as distinguished from that which contemplates or perceives." (1979, p.931)

'Objective sign' was defined in the same dictionary as:

> "... a sign which can be detected by someone other than the patient himself." (p.931)

In Webster's Ninth New Collegiate Dictionary 'objectivity' was defined as:

> "... being an object, phenomenon, or condition in the realm of sensible experience independent of individual thought and perceptible by all observers: having reality independent of the mind

> ...: expressing or dealing with facts or conditions as perceived without distortion by personal feelings, prejudices or interpretations." (1983, p.814)

Clearly, the above definitions of 'objectivity' leave little doubt that the application of 'objectivity' in studying the concept of mental illness is difficult if not altogether impossible.

As already established in the previous chapters, the psychiatric definition of 'mental illness' is based on the categorisation and organising of the lay commonsense perceptions and everyday observations towards what constitutes 'madness'. In many cases, the psychiatrist tries to rationalise and express the lay conception in a more logical sense. Thus the psychiatric concept of many forms of mental illness is to develop and organise stereotype attitudes towards people's lives and behaviour. In other words, the definition of 'mental illness' is a conceptual grouping or configuration rather than an objective fact (Fernando, 1988). That is to say that no psychiatrist can deny that his definition of mental illness is largely based on signs that are detected not by 'doctors' but by someone other than the doctors, i.e. police, relations, etc. Moreover, the psychiatric definition is not independent from individual thoughts and facts that are shaped by "personal feelings, prejudices or interpretations" (Webster, 1983, p.814). Thus, when speaking about objectivity in studying the concept of mental illness, one must be careful not to take the paradigm of biological disease and then complain that mental illness does not fit into this model. In any discussion of the concept of mental illness, one must take into account the

contributions of several different causes, as expressed by the individual himself. The psycho-social dimension, as Skinner in Blumberg (1976) points out, cannot be reduced to a representation of minds, i.e. to a mentalistic explanation, rather it must be observable in terms of behavioural manifestation. Or, as Boorse (1982) argues, mental events cannot be reduced to neural events. This is because in psychiatry we are dealing with motivation and context-dependent systems of thoughts and values. Accordingly, one cannot escape the fact that the clinician's essential tools should be interpretative - for instance, the patient's 'explanatory model' (Kleinman in Fernando, 1988). Such methods get further away from the goal of an 'objective' and value-free understanding of mental illness.

On the conceptual level, the RFD model accepts the limitation outlined above in that it is based on the assumption that as long as we are dealing with illness, we are actually dealing with human experience. The content of human thoughts or experience is essentially a matter of interpretation of the patient's own description. Therefore we cannot possibly evaluate or measure the patient's own values without reference to society's values, the clinician's values and the context of cultural norms in general.

Therefore, any attempt to introduce 'objectivity' into a science of illness will fail if we try to remove these values or to act as if these values are irrelevant to the individual's illness.

If 'objectivity' means independence from values, there can be no objective science of subjective meaning and experience. That is because the content of that science is always interpreted in the light of some values. Thus, all the attempts to introduce the medical model fail, if they are intended to describe illness.

Therefore, the RFD model in addressing mental illness does not seek freedom from values or subjective experience. Its main strength lies basically in explicit recognition of the inherence of values in illness and the fact that no description of that illness is available which is independent from either the patient's interpretation of his own experience or society's values, and the clinician's interpretation of the patient's behaviour.

However, this does not mean that we cannot be systematic in our methods of investigation, or have a relatively clear 'objective' method whose basic aim is to maximise the facts relevant to the disturbed conditions per se and to minimise the effects of extraneous subjective factors (for instance, the clinician's prejudices and beliefs) that have little bearing on the individual's total disturbance. That must be done through the 'patient's' explanatory model which must be given priority over that of the psychiatrist's definition.

In psychiatry our main topics are feelings, perception and subjective meaning. A sufficient understanding of the individual's life and his unique experience require an understanding of what the individual is, the role of context - dependent variables in shaping

his total functioning, and the kind of reasoning the individual attaches to his total functional activities. The importance of 'reason for action' is that it implies a system of motivation and cognitive patterns (a set of beliefs and desires) that can be used to explain the behaviour in question.

Different people ascribe different reasons and meanings to their actions and context-dependent variables play a considerable role in the definition of the system of beliefs and desires that must be incorporated in any form of reasoning. To act in a highly disturbed manner on some occasions should not necessarily lead to the assumption that such a disturbance is systematic or even influential over subsequent behaviour.

> "The fact that they (the mentally ill) act inappropriately today, does not mean that their behaviour was equally dysfunctional yesterday or that it will be so tomorrow." (Ellis, 1967, p.445)

The above discussion highlights the central issues in any proposal to define the concept of mental illness objectively, namely the role of understanding and interpretation of the motivational and cognitive patterns underlying the individual's total functioning. Such understanding cannot be achieved without a sufficient method of interpretation that is appropriate to psychiatry's subject matter. Before discussing the alternative model of RFD proposed in this chapter, we must define what kind of objectivity we are looking for.

Surely not the kind of objectivity suggested in the previous definitions or by the previous writers. It is a fact that the World Health Organisation's study, for example, supports the hypothesis that schizophrenia is found all over the world. It seems that this kind of study, alongside a high rate of mortality and diminished fertility among many schizophrenics, supports Boorse's main arguments, as we mentioned previously. Before answering the above arguments, let us state very clearly that there are certain forms of mental illness where a total failure is very severe, even though temporary, and follows a stabilised or episodic course of deterioration. There would be a strong probability that such total disintegration in the motivational and cognitive level would be relatively immune or resistant to social context. However, universal 'immunity' for other acute psychoses is unproven, and the findings of cross-cultural psychiatry are contradictory, vague and have failed to isolate a single cause or factor that has a significant bearing on most of the conditions described as 'psychoses' (see Rey et al, 1987, and Baskin, 1984).

To illustrate the above, consider the following two cases: The first case was interviewed by the present writer and concerns a Philippino servant working for a Kuwaiti family. She had been with them for three years when, suddenly, one early morning she took a knife and killed two of the children and the grandfather while he was praying. The patient believed she was a prophet from the Philippines on a religious mission to save Philippino girls in Kuwait from what she considered to be a life of degradation (some female servants in the Gulf States have been victims of sexual abuse).

The patient believed that spilling Kuwaiti blood was the only way to redeem the crime committed against her fellow country-women. Thus, she firmly believed that she had carried out a noble religious act and was perfectly satisfied with her actions.

The second case concerns a young man who killed his wife after finding her in bed with another man. Such an act (killing an unfaithful wife) is considered morally justified in Kuwaiti culture - in fact it is the only acceptable way to act in order to preserve the honour of the family.

With respect to the first case, there would be little doubt among mental health professionals across the world about making a diagnosis of 'paranoid schizophrenia'. This is because there is obviously a total, severe negative social consequence (killing) which would appear to be relatively immune to receiving different interpretations in different cultures. To the psychiatrist, the woman's motivational and cognitive processes appear to be totally inappropriate, thus resulting in the act of irrational killing.

The problem which mental health professionals face with such a case is that if her delusion had been of a paranoid nature (e.g. that the family were conspiring to kill her and she needed to get them first), clinicians might be obliged at least to check out her story - to try and falsify their claims concerning their probable intentions. In the case of prophesy - as in our example - there is nothing to check that we could possible understand. The patient's

claims, when considered within their proper context, are 'insane' delusions, pointless, and lack a meaningful content. The woman's beliefs fail to "rationalise" the action precisely because they lack any valid criteria of interpretation.

However, some writers such as Laing would assert that although the patient's actions appear to be irrational, the same cannot be said of her motives. The woman's motivation for killing is consistent with her awareness of the distressing situation of her fellow women in Kuwait. In this light, the set of beliefs and desires motivating the killing is intelligible when one considers those beliefs from the patient's explanatory model. For many psychiatrists, the motives of the patient and the reasons she attached to her actions do not fully rationalise the act of killing. Thus, her total behaviour seems unintelligible which renders the definition of 'mental illness' appropriate.

It might be that there are certain degrees of consistency between the woman's motivation for killing and her cognitive system, i.e. awareness of her fellow women in Kuwait. Such a consistency could only be attained when her delusional system is free from those religious or moral principles that contradict the common sense norms in a given society. If such moral or religious beliefs do not justify the actions which resulted from them, clinicians would be more vulnerable to define such beliefs as an indication of mental illness. In fact, the whole concept of mental illness derived its main definitional properties from the norms of adjustment that each society

applied. In the first case, both the act of prophesy and the act of killing represent a radical deviation from the Kuwaiti norms of adjustment which render the case suitable for psychiatric definition.

The problems arise, however, not from such clear-cut cases, where the actions do not fully justify the motives, but from many borderline conditions in psychiatric daily practice where the deviation from the norms of adjustment or psychiatric 'average' or hypothetical normal individuals is not totally clear. In such conditions, one must be fully prepared to face the following question: "adjustment to what, adjustment to whose standards?" (Beilin in Scott, 1971, p.9).

Until mental health professionals reach the stage where such questions could be reliably answered, one must be fully careful not to ascribe the definition of mental illness on the basis of 'arbitrary' norms of adjustment.

In the second case, there is a strong correlation between the act of killing and the cultural norms of Kuwaiti society on the one hand, and the motivational and cognitive patterns of the individual on the other. Killing, in such circumstances, is perceived as a perfectly acceptable act of 'morality' in Kuwaiti society, and the motivation of the individual in this case is to promote the ethical principles of his society as well as to preserve his own self-esteem. Thus the act of killing is considered to be the logical solution to any serious breach of morality.

Obviously, the same act would receive different considerations in different societies, i.e. some societies would view the act of killing in such circumstances as a psychopathic deviance, while in others it would be considered as anti-social and in still others as a perfectly understandable reaction to the violation of social and moral norms, as in our case. Thus in all cultures there exist clear-cut expectations for functioning in certain contexts. The young Kuwaiti man who killed his wife and who, presumably, might kill a second wife in the same circumstances, and so on, would probably be considered in many cultures as suffering from a disruption in his major social functioning. The inability to comprehend the motivation behind the killing would probably lead to a diagnosis of mental disorder.

Thus, whenever there is a major disruption or radical change in the psycho-social functioning of the individual alongside a total disturbance in the motivational and cognitive patterns underlying psycho-social functioning (as in the Philippino's case), then the frame (though not the content) of the disturbance can plausibly be held to be invulnerable to specific contextual variables. Sufficiently severe disorder, then, is not "merely" a matter of cultural or social judgement, as regards its general form. The precise content of a given individual's disordered experience, however, clearly is still partly determined by its context (see a study by Rey et al (1987) on the psychiatric identification of severe events).

In less severe cases, or when there is only a partial failure, the problem would take another dimension. That is to say that establishing a cross-cultural definition of the individual's suffering becomes highly difficult due to the underlying consistency of motivational and cognitive patterns driving the individual's total functioning. Such patterns are comprehensible and intelligible to the individual himself in the cultural context within which he operates. This means that the clinician needs to be highly familiar with the social and cultural context of the 'patient' in order to establish an appropriate diagnosis. Partial functional failure is highly dependent on social variables because of the presence in the individual of a coherent pattern of motivation that is closely tied to his personal and social context. In fact, even in a severe form of mental disturbance it would be extremely difficult to escape the context-dependent nature of personal motivation, and a number of philosophical and theoretical questions need to be posed regarding the hidden nature of beliefs in, for example, the delusional system of paranoia or schizophrenia. One philosophical consideration which needs to be taken into account is the fact that the psychiatrist cannot and does not stand apart from the person he is observing. "The psychiatrist is committed to some picture of what he considers to be reality" (Szasz, 1973, p.19), and he interprets the problems of the individual according to his own beliefs. In addition, the psychiatrist's socio-ethical orientations and the school of thought he belongs to will also influence his ideas and his definitions of the patient's problems.

> "Psychiatrists thus cannot help but work out an image of humankind - a theory of the person - as they go about their more mundane tasks."
> (Moore, 1984, p.419)

Thus, the inter-subjective understanding of individual suffering and the a priori nature of psychiatric definition threaten any serious attempt to establish objective, cross-cultural methods in defining mental illness. Jaspers, in Slavney and McHugh (1987), outlines the dilemma by stating that:

> "... understanding any particular, real event has to remain more or less an interpretation which only in a few cases reaches any high degree of complete and convincing objectivity. The fewer these (objective data) are, the less forcefully do they compel our understanding; we interpret more and understand less." (p.37)

From everything said so far, it would appear that the interpretative nature of psychiatric definition of mental phenomena must be the central theme in any discussion concerned with subjectivity or objectivity of psychiatric explanation. How, then, can the problem be overcome?

The RFD model presented here suggests the criterion of a contractual relationship between psychiatrist and patient. Such a criterion can be defined as an explicit agreement between the psychiatrist and the patient on the following points: first, mutual agreement between both parties on the factors that have a bearing on the definition of the problem. A third party's conception of the problem would be considered as an additional source of reference if and only if

the causal links are not very clear or the patient's personal reports of his suffering appear inconsistent or irrelevant to his present problem. Thus, a third party account would be viewed as a source of validation or as a useful informant that might help in identifying additional contributory factors in the individual's present disturbance. Secondly, the psychiatrist's interpretation must be fully accepted by the patient. Finally, the patient's personal conception of his problem, the way he perceives himself, and the motives and rationale he attaches to his suffering are the most valid and reliable factors in defining the problem in question (the patient's explanatory model). For this reason, the RFD model emphasises the importance of the patient's own perception of his suffering and his motivation in calling for professional help.

Rogers (1951) realised the centrality of the individual's own judgement when he stated that our problem as mental health professionals is that:

> "We fail to see that we are evaluating the person from our own, or from a fairly general frame of reference but that the only way to understand his behaviour meaningfully is to understand it as he perceives it himself, just as the only way to understand another culture is to assume the frame of reference of that culture. When that is done, the various meaningless and strange behaviours are seen as part of a meaningful and goal-directed activity. There is no such thing as random trial and error behaviour, no such thing as a delusion, except as the individual may apply these terms to his past behaviour." (p.494)

In fact, many writers (Laing, 1983; Szasz, 1987; Scheff, 1967; Ellis, 1967; Rogers, 1951, etc.) have emphasised the importance of the individual's own perception of his suffering as the most valid and meaningful frame of reference for 'reality' as perceived by the patient himself. In any attempt to establish a systematic and conceptually clear definition of individual functional impairment, one must be clear whether the definition is based on a shared interpretation agreement between the 'patient' and the psychiatrist, or, for example, on the claims of a third party.

Before discussing the importance of a shared responsibility in psychiatric definition, let us first give a more detailed account of the significance of the individual's own perception of his problem. The individual's judgement, although important, is not necessarily the only significant criterion in all situations. A third party, or significant 'others', such as family members, the police, friends, etc., may provide additional points of view, but again not necessarily the most reliable ones. Different judgements, therefore, carry different weight. However, it is the individual himself and the way he perceives and experiences his total performance in the three major functions that must be accorded the utmost importance. For it is the individual himself who perceives a given situation as distressing and as bound to affect his functioning, by correlating and assessing the similarities and differences between his feelings and those of others, or by taking into account the way he felt and behaved towards certain problems in the past which proved to be effective in handling the situations (Scheff, 1967). In this way, the individual's self-

description and the clinician's observations together would help to provide sufficient data about the central features of the disturbance (Jaspers, 1923). Such information would contribute in maximising the 'objective' facts of the disturbance and minimising the subjective and irrelevant ones. The individual's claims or self-description should be the most crucial element in the psychiatric definition of his problem, particularly when one considers that the major tool for diagnosis in psychiatry is the interview. Therefore, it seems only natural to emphasise the importance of individual perception as possibly the best source of information about the problem. This is because the only person who knows why the patient is behaving ineffectively, or what his functional disturbance consists of, and what he is doing to maintain the status quo, is the patient himself. He is the only one who can accept his disturbance or refuse to live with it (Ellis, 1967).

One must admit, however, that there are certain psychiatric cases where the patient's total functional failure is so extreme, even though temporary, that it might affect the validity of what the patient says. In those instances, one must allow for the following two alternatives: (i) either to accept the patient's personal assessment or self-referral in conjunction with those around him, or (ii) 'significant others' might be given precedence over the patient's personal claim. In other words, the RFD model, with respect to certain psychiatric cases, accepts an obligation to consider the patient's own evaluation as a merely additional, secondary criterion for deciding the significance of his total suffering.

Now, how can the patient's claims and self-descriptions be taken as a basis for establishing a systematic account of mental illness?

In trying to answer the above question, we shall provide a brief account of what kind of methodical procedures we are looking for and of the role of interpretative agreement between the patient and the psychiatrist. A possible resolution of the above dilemma would be the introduction of a morally systematic approach rather than a conceptual one in the definition of the concept of mental illness.

The Concept of Mental Illness: The attractions of 'objectivity' or the demand for a 'morally advanced perspective' - do we really have a choice?

From the analysis offered above, it has become clear that the psychiatric definition of mental illness is based largely on social factors which play an important role in the definition of concepts such as appropriateness and rationality in terms of individual suffering. But this, as Reidbord (1986) argues in his article "Inappropriate Objectivity in Psychiatry":

> "... is no disgrace to the field, for as Aristotle noted, we do not require the same proof in oration that we do in mathematics. Psychiatry undoubtedly falls in between, and is strengthened or weakened according to the cognisance we grant to our own biases." (p.134)

As we noted earlier in this chapter, many researchers have tried to find an 'objective' value-free definition of mental illness by assuming a causal and deterministic view towards mental illness as in the 'disease' or 'medical' models. In reality, we cannot escape the fact that:

> "... the failure of our understanding and treatment of mental illness is not in the hands of science alone. It depends ultimately on the valuation we place on human existence and human experience ... Whatever course we adopt, we shall be making a number of value judgements of which we may be more or less aware and these will include social judgements about what kinds of behaviour we are going to count as acceptable and what as pathological, judgement of what constitutes happiness and effective living, judgements concerning what aspects of behaviour we should suppress and what we should try to understand."
> (Carni and Smail, 1969, p.173)

The above quotation states clearly that the role of valuation and understanding are central elements in any psychiatric definition of mental phenomena. Both the descriptive and explanatory processes are incorporated in the interpretative process in psychiatry (Ingleby, 1981). Moreover, these quotations emphasise the role of non-clinical factors in the psychiatric definition of mental illness, i.e. social criteria rather than objective ones (symptoms alone).

For that reason, the RFD recognised at the moral level the vulnerability of the patient to non-clinical judgement (social definition) of non-conformity that is based on societal and familial values. Therefore the RFD model insists that we ought to make the patient's own values central as they are expressed in his own account

of his experience or illness. That is to say that we must replace the dominant position given to social values with the dominant role of patient's values and we must define our diagnostic procedures with this changing priority in values in mind. The RFD's main emphasis is to re-interpret such claim of 'objectivity' and to put the patient's values and autonomy on the centre rather than society's values. Autonomy is the justification for the RFD model. The patient's decision in the light of his own reason and preferences without undue constraint must lie at the very base of psychiatric practice. As a result we will be able to avoid the risk of different forms of psychiatric abuse which we discussed earlier, i.e. clinical and political abuse.

This preference for the patient's values over society's values is in itself a moral preference, not a conceptual revision of DSM-III. It is grounded in a moral preference for the ethics and values of self-government or self-control as a central moral principle. Therefore the RFD model does represent in this respect a moral advance over DSM-III (in moral terms).

Being able to make a choice of this kind does not imply that psychiatry totally lacks a systematic procedure. Nevertheless, it is difficult, if not altogether impossible, to look for scientific methods in the area of experience and feelings, or to deny the presence of values. Irresponsible parenting, for example, may or may not be taken as a cause of anti-social deviation and such behaviour may not count as a basic personality characteristic (Blackburn, 1988).

That does not mean that we are not able to have a systematic approach in the definition of mental illness that is based on both interpretation and self-description methods. Certainly one cannot ignore the effects of context, meaning and purpose of the individual's functions in any given methods of interpretation, unless, as Boorse (1981-1982) suggests, it is possible to confine ourselves to functions so fundamental and pervasive as to be counted 'natural' to our species. Impairment in such 'natural' functions would be understood as a 'disease' (leading to illness if severe enough to be incapacitating, undesirable, etc.). But such functions are too general to be of use in understanding individual experience. It seems therefore that the only possible account for establishing a relatively systematic and reliable interpretation approach in psychiatry is to assume a systematic symptom-interpretation approach based on the individual's personal account of his disturbed functions. In other words, instead of establishing a context-independent definition of the individual's subjective distress one must consider an approach or method which is equipped to suit and accommodate the diversity of psychiatric variables in an individual's background. A method that can be described as 'systematic' must be viewed as individually centred if it takes into consideration the diagnostic agreement between the patient and the psychiatrist as in itself a valid representative procedure. Thus, the above approach or method would be comprehensible only in terms of a mutual agreement on the content and meaning of psychiatric interpretation between both the patient and the psychiatrist.

The following conditions need to be fulfilled in order to maximise the validity of the above approach and to minimise the influence of irrelevant factors:

1. The patient must be aware of a total breakdown in his major functioning.
2. The patient himself must seek specialised help.
3. The clinician and the patient must enter an agreement which is characterised by shared responsibility on the contents and purpose of psychiatric interpretation. The main features of such an agreement can best be summarised by the following quotation from Rogers (1961):

> "The client is freely able to express his feeling in its complete intensity as a 'pure culture' without intellectual inhibitions or caution, without having it bound by knowledge or contradictory feelings; and I am able with equal freedom to experience my understanding of their feeling, without any conscious thought about it, without any type of diagnostic or analytical thinking, without any cognitive or emotional barriers to a complete 'letting go' in understanding." (p.202)

When the individual and the psychiatrist enter a relationship where there is a 'complete letting go in understanding' between each other, a relatively high degree of agreement on the main features of the disturbance would be attained.

4. Both the patient and the mental health professionals must agree throughout the interpretative process on the content, meaning and purpose of the disturbed functions.
5. The interpretation of the functional failure must be viewed as a probability or a possibility rather than as a predetermined fact (Walker, 1985; Torrey, 1974).

Thus, the absence of any preconceptions about the functional failure of the individual will result in an active participation by both parties in the exchange of ideas about the individual and how he perceives his social environment as well as his motivational and cognitive processes. As a result, the clinician would gain a more meaningful perception of what appears as irrational and the content of the disturbance would be more intelligible. In this way, the interpretative agreement between patient and clinician can be viewed as an effective 'letting go' procedure which would facilitate a genuine participation and a mutual understanding on the central features and contents of the individual's disturbance.

Diagnostic decision, therefore, is likely to identify with the patient's, rather than with society's, perspective. As a result, the content and meaning of the individual's total failure would be more comprehensible to the psychiatrist. This would be achieved when both the psychiatrist and the patient engaged in a mutual frame of reference and understanding to the main feature of the disturbed function.

Thus one is able now to conceptualise an account that is merely a preference among competing values, an approach that is substituting the patient's values for society's values. That does not mean that the above approach is totally 'free' from the values of society. Indeed, the patient's own values will not be totally independent of society's values. One cannot escape the fact that to understand the patient's values, one must make a reference to the context of society's values.

The emphasis on the patient's own values, however, would be justified on the grounds that such values are those which are considered by most members of society as being 'out of touch with reality' or 'bizarre' or deviations from what one considered to be standard values.

In fact, when we make the patient's values central, rather than society's, that is a moral rather than a conceptual preference or choice. In reality, one cannot dispense with society's values as a frame of identification and reference - that is in fact a logical constraint. Without this frame of reference, diagnosis would be in a conceptual vacuum - chaotic and idiosyncratic, in fact bizarre and meaningless itself. We recognise any forms of 'disorder' only by having available to us some "order" with which to contrast it.

On the moral and perhaps the conceptual level, nevertheless, the patient's values when dealt with by the clinicians as highly indicative and relevance to the patient's present problems, this will eventually help the clinician to isolate specific factors or attitudes that have great bearing on the causation of the problems as conceived by the patient himself.

Again, to isolate such factors the psychiatrist has to rely heavily on an interpretation method alone. It might be argued, however, that such a method in psychiatry represents a 'weak' form in comparison to the well-established methods of internal medicine. However, interpretation is a basic tool for psychiatric reasoning

and mental health professionals have little choice but to accept its validity. Thus we are not dealing with one universal view of RFD that can be applied to all contexts. Instead, different individual cases might be involved in different levels of psychiatric interpretative agreement and therefore need different diagnoses. Each diagnosis is a reflection of the context and purpose of the disturbed function and is relatively free from institutional norms or the clinician's subjective view. Moreover, the definition represents the logical conclusions of what both the patient and the psychiatrist have agreed upon. Therefore, patient 'A' is likely to receive a different diagnosis from patient 'B' even though both 'A' and 'B' share the same 'symptoms'. As patient 'A' and patient 'B' have a different system of values and different motivational and cognitive systems, their total functional failure would have a content which is unique to each one of them. However, despite the differences in the two cases, they would both enter in a 'psychiatric interpretative agreement' with the health professional in charge of their cases, and they would both have to agree on the validity of the psychiatric diagnosis of their suffering. Accordingly, the psychiatric diagnosis for patient 'A' and patient 'B' would be considered as a valid description of what both cases have agreed upon during the process of 'psychiatric interpretation'. As a result, the psychiatric diagnosis would be more representative and the data collected would be viewed as reflecting the variables which affect the major functioning of patients 'A' and 'B'.

In actual psychiatric practice, of course, one cannot deny the fact that there are individuals who suffer from severe and chronic

disorders which result in a complete breakdown of their cognitive and motivational systems. In such cases, there exists an ethical and professional obligation on the part of mental health professionals to accept either a temporary 'active-passive' relationship until the disorganisation of the individual's cognitive and motivational system becomes less severe (Irwin, 1985), or a type of relationship where the "patient remains relatively but not completely aloof while the physician gives greatly of self" (Friedlander, 1982, p.1716).

As we noted earlier, there are a few cases in psychiatric practice where the form of severity of functional failure is relatively unquestionable in almost any context. In such cases, the total breakdown of the individual's cognitive and motivational system make his condition relatively easy to identify in almost all contexts, i.e. indiscriminate killings, chronic and severe aggressive behaviour, etc. Thus many studies have shown that psychiatrists are likely to have a far higher level of agreement on the diagnosis of major psychotic disorders than on the diagnosis of neurotic disturbance (see Rey et al, 1987). The problem is that not all psychiatric cases represent a severe and chronic functional failure. Moreover, even in the few such cases one cannot ignore the effects of context on the content of disturbed functions, especially if the total functional failure appears unintelligible or ambiguous. In such cases, when the context might determine the results, the clinician needs to relate the symptoms to an interpretation of the context which would help him to make sense of the symptoms presented to him.

In conclusion, what we are looking for is a shared responsibility model in the form of an autonomous contractual relationship between both the patient and the psychiatrist. This kind of relationship, as Szasz (1972) puts it convincingly:

> "... implies that a patient might set himself goals at variance with the values of his therapist; the patient may change in ways not specifically intended by the therapist, and indeed contrary to the therapist's personal preference." (p.255)

In other words, a type of ideal patient-psychiatrist relationship must be the kind suggested by Friedlander (1982) when the "patient gives greatly of self but the physician enters only slightly into the patient's personhood" (p.1716).

This type of relationship can facilitate the conditions for both parties (patient and psychiatrist) to debate and agree in consultation on what constitutes an acceptable psychiatric interpretation of the presented problem.

The present writer believes that such form of participation by both the patient and the clinician in the formation of psychiatric definition would minimise the effects of preconceived and predetermined evaluation. Thus, it seems possible to believe that procedures based on mutual interpretation rather than on notions of cause, etiology or symptoms could create an international perspective on how a systematic working method of psychiatric intervention could be enhanced through the involvement of the patient in the psychiatric definitional process.

Future goals, consequently, should be directed towards establishing an international perspective on the importance of shared responsibility and participation between patient and psychiatrist. An universal recognition of the validity of such procedures of interpretation is the only hope for the safeguarding of the individual's right to an appropriate diagnostic account of his suffering in any psychiatric (diagnosis) method.

Conclusion

There is a strong temptation among many psychiatrists, especially the organic ones, to ignore the role of cultural and social factors in the definition of the concept of mental illness. Such a perspective does not take into consideration the patient's personal philosophy based on his socio-ethical background. Such attempts to define the concept of mental illness "carry the weight of biological law" (Lazarus, 1975, p.175).

However, the reality of "biological law" as something which is basically related to physio-chemical criteria alone must be examined carefully. Such belief in the absolute determination of physio-chemical factors would consequently lead to dismiss the importance of emotional humanistic factors implied in the practice of medicine in general and the genesis of disease in particular, which eventually dehumanizes the practice of medicine.

An objective or value-free definition of the concept of mental illness would not, on the other hand, necessarily do away with the pejorative connotation and promotive nature of being mentally ill which is somehow inherent in the concept of illness itself. What is more, even if one accepts the possibility of establishing a value-free definition of extreme forms of mental illness, such as schizophrenia, manic-depressive psychosis, etc., one cannot ignore the fact that there are a great number of marginal cases where causal laws are too complicated to trace. It has to be accepted, therefore, that a definition of mental illness in such cases is bound to be highly tenuous.

The present writer believes that recent attempts to establish a value-free definition of mental illness are based more on a hypothesis than well-established facts. What mental health professionals need to address is the moral consequences of being defined as mentally ill. Thus, instead of trying to find commonality of cause, mental health professionals need to direct their efforts towards finding a commonality of outcome in the consequences for the individual of being labelled as 'mentally ill'. In other words, mental health professionals need to address themselves to the moral and ethical problems of defining individuals as 'mentally ill'.

The objective or value-free perspective in Sarbin's (1967) words:

> "... may be formualted as the question, what criteria should be employed to deprive a man

> of his liberty, his civil rights, his capacity for self-determination, and so on?" (p.452)

Although the problem is not in itself to do with finding a 'proper' definition of the concept of mental illness, it has, nevertheless, much to do with the moral consequences of such a definition. Such consequences would differ from one context to another. A Kuwaiti patient, for example, would accept a psychiatric definition that he is incompetent, within the framework of the Islamic tradition of accepting what happens to one as inevitable, or resigning oneself to the environment. Such a view, however, might be unacceptable to someone brought up in the egalitarian and individualistic tradition of Western culture which gives centrality to the idea of competency as:

> "... reflecting our commitment to struggle against and control the environment, to act against events or to make them happen, to transform them in accordance with our needs."
> (Lazarus, 1975, p.21)

In this chapter, the present writer has tried, through the RFD model, to accommodate a range of diverse issues centred round mental illness as a value-free concept. The RFD model can best be summarised as resting upon the following conditions which are seen as necessary for the proper application of the concept of mental illness to a given individual:

1. There is a total failure in the individual's major psycho-bio-social functioning.

2. The individual admits to feeling 'ill'.

3. The individual seeks professional help.

It was further argued that even in the clear-cut psychiatric conditions where there is a total failure in the individual's major functioning, accompanied by a severe disturbance of the individual's motivational and cognitive abilities, one cannot view such conditions as totally immune to social and cultural factors. Indeed, mental health professionals cannot dispense with contextual influences as a frame of identification and references or the subjective psychiatric interpretation of the patient's system of values.

The RFD model also emphasises the importance of the individual's own description of his disturbance as a necessary condition for entering into a shared interpretative agreement with the psychiatrist. Both the patient and the psychiatrist should come to a mutual acceptance of the diagnosis of the problem of functional failure. Thus, the agreement reached is likely to reflect more appropriately the shared perspective of patient and psychiatrist, and it would then seem possible to argue for an 'all-context' application of the psychiatric model of patient participation to the definition of the concept of mental illness to the extent that "co-operation" and "shared participation" would be understood to mean the same thing in different contexts.

It has become clear that the 'biological' or 'disease' model cannot provide a satisfactory answer to notions such as 'participation' and 'interpretation'. Moreover, even if science

succeeded in doing so, it would be difficult to imagine that questions such as whether the manifested function is appropriate or inappropriate, reasonable or unreasonable can be solved by physical medicine alone.

The question which needs to be addressed here is not whether we can claim any success in making an analogy or a distinction between psychiatry and internal medicine, but how such an analogy or distinction can contribute to establishing a more constructive method for the formulation and understanding of the concept of mental illness from both a professional and a moral perspective, or of how mental health professionals respond to people who are 'objectively diseased'.

CONCLUSIONS

It was suggested in Chapter one that psychiatric services in Kuwait are in a state of moral crisis. The development in psychiatric services in Kuwait in recent years shows that mental health professionals have not travelled far beyond the walls of the old 'asylum'. It was shown that the diagnostic process and the management of psychiatric patients in Kuwait is lacking in sound clinical judgement and ignores the individual patient as a prima facie moral agent who has the right for self-definition and autonomous choices.

In trying to establish the hidden factors that lie behind psychiatric abuse, we discussed in Chapter two the limitation and weakness of the concept of mental illness which render the concept vulnerable to abuse. It was argued that the current definitional systems in psychiatry, as mainly represented by DSM-III, although providing clinicians throughout the world with a single definition of mental illness, are not used consistently by all countries in their practice of psychiatry. Moreoever, such a single definition of mental illness does not prevent many mental health professionals from using their subjective or personal impressions in reaching the psychiatric diagnosis. As a result, certain clinical, terminological, and moral limitations arise.

In Chapter two, it was established that human problems are too diverse and complicated for any definitional system in psychiatry to conceptualize. It was further argued that the negative

outcome of a psychiatric diagnosis outweigh in many instances the value of such definitions.

In Chapter three, we proposed a functional approach to the concept of mental illness. This approach was called the Reactive Functional Disorder (RFD). The RFD model highlights the vulnerability of the concept of mental illness to psychiatric abuse and the importance of the concept of totality in studying functional disturbance and in reducing the problem of psychiatric abuse. The RFD emphasises 'abnormality' as related to specific functions as they are perceived and experienced by the individual himself, and the importance of viewing human problems as a reaction towards external pressures rather than as residing inside the individual. In that respect, the RFD account emphasises the importance of a context-dependent interpretation of the content of any psychiatric symptoms.

The RFD approach puts a great deal of emphasis on promoting the patient's right for self-determination and self-definition. These aims would be established through the application of a rational, autonomous and contractually-based psychiatry. Such contractually-based psychiatry can be generalized in all contexts. Accordingly, the content and frame of most psychiatric problems would have a great validity and be highly reflective of the patient's actual suffering.

In addition, the RFD approach emphasizes the meaning the 'patient' ascribes to his psychiatric problems. The meaning which the individual attaches to his suffering is considered to be an

important qualifier, as important as the general question of context. The individual patient may well suffer, but it could be rational and meaningful to do so.

In fact, giving precedence to the patient's values and the meaning he ascribes to his problems over social values is a moral rather than a conceptual choice. In reality, one cannot dispense with social values as a frame of identification and reference. Without such a frame of reference, diagnosis would be in a conceptual vacuum - chaotic and idiosyncratic, in fact, bizarre and meaningless itself.

We recognize any form of psychiatric disorder only by having available to us some 'order' with which to contrast it. On the moral and perhaps the conceptual level, nevertheless, the patient's values, when dealt with by the psychiatrist as highly indicative and relevant to the patient's present problem, will help the psychiatrist to isolate specific factors that have a great bearing on the individual's problem.

The RFD model incorporates the patient's own judgment of the degree to which his major functions have deteriorated. This reference to the patient's own interpretation represents a crucial step away from the dangerous reliance, in the DSM-III model, upon the psychiatrist's subjective or personal experience.

In Chapter four, we established the fact that although Thomas Szasz takes an extreme attitude towards the concept of mental

illness and considers psychiatry as completely governed by moral values, he has nevertheless, contributed to promoting many central ethical principles in the practice of psychiatry. Szasz's arguments on the vulnerability of the concept of mental illness to abuse, and on the moral outcome of psychiatric terminology and the need for contractual psychiatry, have directed psychiatric practices and research towards a more careful consideration of the limitations and weaknesses of the concept of mental illness. Furthermore, Dr. Szasz's writings have prompted and encouraged concern for the patient's right to self-government.

In Chapter five, we established that the political abuse of psychiatry in the Soviet Union has become a systematic state policy. Such political abuse is largely based on a concept of mental illness and a diagnostic scheme (founded by Snezhnevsky) that can accommodate many normal individuals under its umbrella. Many political dissenters have been diagnosed as 'sluggish schizophrenics' on the basis of non-conformity rather than on the basis of clear objective symptoms. In this chapter we have also made an attempt to show how the RFD model might provide some guidelines for dealing with the problem of psychiatric abuse in the Soviet Union. One of these guidelines is that mental illnesses be identified on the basis of a basic and total disturbance in the individual's major psycho-physio-social functions. A second is that the disturbance be the result of a reactive process towards external rather than internal factors. Thirdly, we stressed the importance of the individual's personal claim of his suffering as a possible indicator for the severity of his disturbed functioning.

Throughout this chapter, emphasis was placed on the importance of being fully aware of the content and frame of functional failure and the role of the 'third party' in the final psychiatric definition. Fourthly, we drew attention to the importance of encouraging a self-referral approach and a contractual relationship between the 'patient' and psychiatrist that is based on a mutual agreement between them as to what should constitute normal or abnormal functioning. If we apply those principles to political psychiatric dissenters, it would become clear that most of them do not suffer from any forms of psychiatric conditions.

Thus, the RFD account, when applied theoretically to case analysis, highlights the problems of Soviet psychiatric abuse, while remaining invulnerable to the kinds of abuse we see in Western countries.

In the final chapter, it was established that it is very difficult to construct value-free methods for conceptualizing and dealing with mental phenomena. It was argued that attempts to establish an objective account of mental functions have not so far succeeded in showing that there are systematic or organized accounts of inner mental functions, in other words, in understanding the content of the psychiatric disturbance.

It was shown that the disease model is not altogether appropriate when applied in psychiatry. It was also argued that confining ourselves to a physicalist's interpretation of physiological

conditions and then extending such an interpretation to psychological conditions is not a profitable method for explaining psychiatric disturbance. That is because human behaviour and experience rather than organic pathology should be the main interest in psychiatric investigation. Thus, it is difficult to conceive of the possibility that neural functions in the body could be related to or identical with mental functions. However, this does not mean that we cannot be systematic, even if not totally objective, in our view of many forms of mental illness or human suffering in general.

One cannot deny that an individual's problems must be defined and classified in order to identify them and help the individual. What mental health professionals also need to do, however, is to address themselves to the moral and ethical consequences of diagnosing or classifying individuals as mentally ill.

A central question, therefore, is not whether we can claim to make an analogy or a distinction between psychiatry and internal medicine but how such an analogy or distinction can contribute to establishing a more constructive method for the formulation and understanding of the concept of mental illness from both a professional and a moral perspective.

The RFD model has been developed in the hope that it might add a moral dimension to the current concepts of mental illness. It has been suggested that future researchers must address themselves to the moral and ethical problems of defining individuals as mentally ill.

In this thesis, we have established the need to promote the patient's role in a shared interpretative agreement with the psychiatrists where both parties come to a mutual acceptance of what should be defined as a psychiatric condition. Furthermore, we have emphasized the role of the patient's personal report about his suffering as a possible indication for his functional failure and the need to be highly cautious towards 'third party' claims.

The basic justification of the RFD model is that it affirms the patient's right to autonomy and self-determination.

BIBLIOGRAPHY

In this bibliography, I have not only cited those works which are referred to in my text, but also to those references which are not cited but nevertheless contribute indirectly in shaping my general attitudes towards the subject.

After Dark "Its a Mad Mad World", a T.V. interview with a group of psychiatrists (including Thomas Szasz) and ex-mental patients. An Open Media Production for Channel 4, 24 July 1988.

Alanen, Y.O. (1984) 'On Psychiatric Illness Models and the Research Methods Connected with them', Psychiatric Fennica 15, pp.9-18.

Al Ansari, E.A. (1985) Evaluation of Psychiatric and Mental Health Services in Kuwait, Department of Psychiatry, Faculty of Medicine, July. (A Confidential Report presented to the Minister of Public Health in Kuwait).

Allman, L.R. and Jaffe, D.T. (1978) Abnormal Psychology in the Life Cycle, Harper & Row Publishers. London: New York.

Al Mutawa, M. (1986) Psychiatry in Kuwait, Press Agency, Kuwait.

Al Mutawa, M. (1987) Psychiatric Nursing in Kuwait, Press Agency: Kuwait.

American Psychiatric Association (1980) 'Quick Reference to the Diagnostic Criteria from DSM-III. Washington D.C: APA.

American Psychiatric Association (1987) Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R) Washington D.C: APA.

American Sociological Association (1979) Explanations of Mental Illness, an Editorial. A paper presented at the 72nd Annual Meeting, September, Chicago, p.385.

Appleton, W.S. (1976) 'The Importance of Psychiatrist telling Patients the Truth'. In Gorovitz, S. et al., (ed.) Moral Problems in Medicine, Prentice-Hall Inc: New Jersey and U.K.

Arieti, S. (1971) 'An Overview of Schizophrenia from a Predominantly Psychological Approach'. In Shean, G. (ed.), Dimensions in Abnormal Psychology, Rand McNally College Publishing Company: Chicago.

Atkinson, R.L. et al., (1953) Introduction to Psychology, Eighth Edition, Harcourt Brace Jovanovich, Inc: London.

Ausubel, D.P. (1974) 'Personality Disorder is Disease'. In Neale, et al., Contemporary Readings in Psychopathology John Wiley and Sons, Inc: London and New York.

Back, K.W. (1973) 'The Psychiatrist: Healer, Prophet, Both or Neither', Soc.Sci.Med. Vol.7, pp.831-838.

Bachrach, L.L. (1988) 'Defining Chronic Mental Illness: A conceptual paper', Hospital and Community Psychiatry, Vol.39, No.4, April, pp.383-388.

Bandura, A. (1974) 'A social-learning explanation of deviant behaviour'. In Morris, R.J. (ed.), Perspectives in Abnormal Behaviour, Pergamon Press Inc: Oxford.

Baskin, David (1984) 'Cross-Cultural Categorizations of Mental Illness', The Psychiatric Forum, May (12) 1. pp.36-44.

BBC 2 (1989) Special Programme on Mental Illness (Interview with Thomas Szasz, Anthony Clare, Friday 10 February.

Becker, H.S. (1963) Outsiders, The Free Press: New York and London.

Ben-Tovim, D.I. (1985) 'DSM-III in Botswana: A field trial in a developing country', Americn Journal of Psychiatry 142:3 March. pp.342-345.

Berke, J.H. (1977) Butterfly Man: Madness, Degradation and Redemption, Hutchinson & Co., Ltd: London and Melbourne.

Birchwood, M.J. et al., (1988) Schizophrenia: An Integrated Approach to Research and Treatment Vol.6, pp.381-39.

Blackburn, R. (1988) 'On Moral Judgements and Personality Disorder: The myth of psychopathic personality revisited', British Journal of Psychiatry, 153, pp.505-512.

Blakiston's Gould Medical Dictionary (1979) Fourth Edition, McGraw-Hill Book Company, New York.

Bloch, S. (1982) What is Psychotherapy. Oxford University Press: Oxford, New York. p.69.

Bloch, S. (1984) 'The political misuse of psychiatry in the Soviet Union'. In Bloch, S. and Chadoff, P., Psychiatric Ethics, Oxford University Press: London and New York.

Bloch, S. and Reddaway, P. (1977) 'Russia's Political Hospitals: The abuse of psychiatry in the Soviet Union', Victor Gollancz Ltd: London.

Bloch, S. and Reddaway, P. (1985) 'Psychiatrists and Dissenters in the Soviet Union'. In Stover, E., and Nightingale, E. (eds.), The Breaking of Bodies and Minds; Torture, Psychiatric Abuse, and the Health Profession, W.H.Freeman and Co., New York, American Association for the Advancement of Science.

Bloomfield, T.M. (1976) 'About Skinner: Notes on the theory and practice of "Radical Behaviourism"', Philosophy of the Social Sciences, Vol.6, pp.75-82.

Blumberg, D. (1976) 'Skinners's latest', Philosophy of the Social Sciences, Vol.6, pp.83-86.

Boorse, C. (1981) 'On the distinction between disease and illness'. In Caplan, A.L. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

Boorse, C. (1982) 'What a theory of mental health should be'. In Edwards, Rem., B., Psychiatry and Ethics, Prometheus Books: London and U.S.A.

Bowers, M.B. (1974) Retreat from Sanity, Human Science Press: New York.

Boyd, J.H. et al., (1984) 'Exclusion Criteria of DSM-III: A study of co-occurrence of hierarchy-free syndromes', Arch.Gen.Psychiatry, Vol.41, October, pp.983-989.

Brecher, B. (1987) 'Mental Illness and giving good reason'. In Lamb, D. et al., (eds.), Explorations in Medicine, Vol.1, Avebury, Aldershot, U.S.A., Hong Kong, Sydney.

Brody, E.B. (1981) 'Szasz on Mental Illness'. In Caplan, A. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

Brody, E.B. (1985) 'Patients' Rights: A Cultural Challenge to Western Psychiatry', American Journal of Psychiatry 142:1, January, p.60.

Brown, B.S. (1975) 'The interface between Psychiatry and Politics'. In Freedman, A.M. et al., (eds.), Comprehensive Textbook of Psychiatry, Vol.2, Second Edition, The Williams & Wilkins Company, Baltimore.

Brown, G.W. (1973) 'The Mental Hospital as an Institution' Soc.Sci. & Med., Vol.7, pp.407-424.

Brown, P. (1985) Mental Health Care and Social Policy, Routledge and Kegan Paul: Boston, London.

Brown, W.M. (1985) 'A Critique of Three Conceptions of Mental Illness', The Journal of Mind and Behaviour, Autumn, Vol.6, No.4, pp.553-576.

Busfield, J. (1986) Managing Madness, Hutchinson: London and Melbourne.

Caine, T.M. and Samail, D.J. (1969) The Treatment of Mental Illness, University of London Press Ltd: London.

Callahan, D. (1976) 'Biomedical Progress and the Limits of Human Health'. In Veatch, R.M., Branson, R. (eds.), Ethics and Health Policy, Ballinger Publishing Company: Cambridge Massachusetts. A subsidiary of Harper & Row Publishers, Inc.

Callahan, J.C. (1984) 'Liberty, Beneficence and Involuntary Confinement', Journal of Medicine and Philosophy 9, pp.261-293.

Chodoff, P. (1984) 'Involuntary Hospitalisation of the Mentally Ill as a Moral Issue', American Journal of Psychiatry, 141, pp.384-389, March.

Chodoff, P. and Peeb, R. (1983) 'The Psychiatric will of Dr. Szasz', The Hasting Center Report, April, pp.11-13.

Chamberlain, J. (1985) 'Inside the Mental Patients' Association'. In Brown, P. (ed.), Mental Health Care and Social Policy, p.329. Routledge & Kegan Paul: London and Boston.

Clare, A. (1976) Psychiatry in Dissent: Controversial Issues in Thought and Practice, Tavistock Publications Ltd: U.K. and New York.

Clark, A. (1980) Psychological Models and Neural Mechanisms: An examination of reductionism in psychology. Clarendon Press: Oxford.

Cocozza, J.J. and Steadman, H.J. (1978) 'Prediction in Psychiatry: an example of misplaced confidence in experts', Social Problems, 25, pp.253-277.

Cocozza, J.J. and Steadman, H.J. (1985) 'Prediction in Psychiatry: an example of misplaced confidence in experts'. in Brown, P. (ed.), Mental Health Care and Social Policy, Routledge & Kegan Paul, London, Boston.

Cohen, D. (ed.) (1987) The Power of Psychology, Croom Helm, London, New York.

Cohen, D. and Cohen, H. (1986) 'Biological Theories, Drug Treatments, and Schizophrenia: A critical assessment', Journal of Mind and Behaviour, Winter, Vol.7, No.1, pp.11-36.

Coleman, J.V. (1967) 'Social Factors Influencing the Development and Containment of Psychiatric Symptoms'. In Scheff, T.J., Mental Illness and Social Processes, Harper and Row Publishers: New York and London.

Collier, A. (1977) R.D.Laing: The Philosophy and Politics of Psychotherapy, The Harvester Press: U.K.

Cooper, J.E. (1988) 'The Structure and Presentation of Contemporary Psychiatric Classifications with special reference to ICD-9 and 10', British Journal of Psychiatry (Suppl. 1), Vol.152.

Costello, C.G. (ed.) (1970) Symptoms of Psychopathology: A Handbook, John Wiley & Sons Inc: New York and Chichester.

Crown, S. (1970) Essential Principles of psychiatry, Pitman Medical and Scientific Publishing Company Ltd: U.K.

Davison, G.C. and Neale, J.M. (1986) Abnormal Psychology: An experimental clinical approach, Fourth Edition, John Wiley & Sons: New York and Chichester.

Dollard, J., Miller, N.E. (1973) 'How Symptoms are Learned'. In Millon, T. (ed.), Theories of Psychopathology and Personality, Second Edition, W.B.Saunders & Company: London, Toronto.

Dorwart, R.A. (1988) 'A ten-year follow-up study of the effect of deinstitutionalization', Hospital and Community Psychiatry, March, Vol.39, No.3.

Drummond, M.F. (1980) Principles of Economic Appraisal in Health Care, Oxford University Press: Oxford, New York.

Dyer, A.R. (1988) Ethics and Psychiatry: Towards Professional Definition, American Psychiatric Press Inc: U.S.A.

Eaton, M.T., Peterson, M.H., and Davis, J.A. (1985) Textbook of Psychiatry, Medical Examination Publishing Co., Inc: U.S.A.

Edwards, R.B. (1982) 'Mental Health as Rational Autonomy'. In Edwards, R.B., Psychiatry and Ethics, Prometheus Books, New York.

Edwards, R.B. (1983) 'A Response to "On being Mentally Healthy"', Journal of Medicine and Philosophy, 8, pp.199-201.

Ellis, A. (1967) 'Should some people be labelled mentally ill', Journal of Consulting Psychology, Vol.31, No.5, pp.434-446.

Engle, G.L. (1978) 'The need for a new Medical Model'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Engelhardt, T.H. (1981) 'The Concepts of Health and Disease'. In Caplan, A.L. et al., (eds.), Concept of Health and Disease: Interdisciplinary Perspectives, Addison-Wesley Publishing Company: London.

Eysenck, H.J. and Eysenck, S.G.B. (1969) Personality Structure and Measurement, Routledge: London.

Eysenck, H.J. (1973) 'Learning Theory and Behaviour Therapy'. In Millon, T. (ed.), Theories of Psychopathology and Personality, Second Edition, W.B. Saunders & Company: Philadelphia, London, Toronto.

Fabrega, H. (1978) 'The Scientific Usefulness of the Idea of Illness'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Fabrega, H. (1981) 'Concepts of Disease: Logical Features and Social Implications'. In Caplan, A. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: London.

Fabrega, H. (1987) 'Psychiatric Diagnosis: A Cultural Perspective', Journal of Nervous and Mental Disease, Vol.175, No.7, July, pp.383-394.

Fairbairn and Fairbairn (1987) Psychology, Ethics and Change, Routledge: London. p.108.

Farber, B.A. (ed.) (1983) Stress and Burnout in the Human Service Professions, Pergamon Press: Oxford.

Farrell, B.A. (1979) 'Mental Illness: A conceptual analysis', Psychological Medicine, 9, pp.21-35.

Farrell, B.A. (1985) 'Philosophy and Psychiatry: Some reflections on the nature of psychiatry'. In Shepherd, M. (ed.), The Scientific Foundation of Psychiatry, Cambridge University Press: London and New York.

Faulder, C. (1985) Whose Body Is It?: The Troubling issue of informed consent, Virago Press Limited, London.

Faust, D. and Miner, R.A. (1986) 'The Empiricist and His New Clothes: DSM-III in Perspective', American Journal of Psychiatry, 143:8, August, pp.962-967.

Fernandez, G. (1981) 'The Social Structure of the Medical Model of Madness and the Physician's Role', Psychiatry, Vol.44, August, pp.241-252.

Fernando, T. et al., (1986) 'The Reliability of Axis V of DSM-III', American Journal of Psychiatry, 143-6 June, pp.752-755.

Fernando, S. (1988) Race and Culture in Psychiatry, Croom Helm: London and New York.

Fields, L. (1987) 'Exoneration of the Mentally Ill', Journal of Medical Ethics 13, pp.201-205.

Frankel, V.E. (1967) Psychotherapy and Existentialism, Washington Square Press, Published by Pocket Books New York.

Frankel, V.E. (1988) Man's Search for Meaning, Hodder and Stoughton: London, Sydney, Auckland, Toronto. Translated by Ilse Leasch.

Freedman, B. (1981) 'Competence, Marginal and Otherwise: Concepts and Ethics', International Journal of Law and Psychiatry, Vol.4, pp.53-72.

Freudenberger, H.J. (1980-1985) Burn-Out: The high cost of high achievement, Arrow Books: London.

Friedlander, W.J. (1982) 'The Basis of Privacy and Autonomy in Medical Practice: A Model', Social Science and Medicine, Vol.16, pp.1709-1718.

Frith, C.D. and Done, D.J. (1988) 'Towards a Neuropsychology of Schizophrenia', British Journal of Psychiatry, 153, 437-443 Review Article.

Fuhrer, R. et al., (1986) 'Diagnostic reliability among French psychiatrists using DSM-III criteria', Acta.Psychiatr. Scand., 73:12-16.

Gillon R. (1985) Autonomy and Consent. In Lockwood, M. (ed.), Moral Dilemmas in Modern Medicine, Oxford University Press: New York and London.

Goffman, E. (1961) Asylums, Harmondsworth, Penguin Books: U.K.

Goffman, E. (1986) Stigma, Harmondsworth, Penguin Books: U.K.

Gorenstein, E.E. (1984) 'Debating Mental Illness: Implications for Science, Medicine and Social Policy', American Psychologist, January, Vol.39, No.1, pp.50-56.

Gove, W.R. (ed.) (1982) Deviance and Mental Illness, Sage Publications: U.S.A. and London.

Gove, W.R. (1982) 'The current status of the labelling theory of mental illness'. In Gove, W.R., Deviance and Mental Illness, Sage Publications: U.S.A. and London.

Greenland, C. (1970) 'Mental Illness and Civil Liberty', G. Bell & Sons, London - Occasional Papers on Social Administration No.38, p.17.

Greenley, J.R. (1975) 'Alternative views of the Psychiatrist's Role'. In Scheff, T.J. (ed.), Labelling Madness, Prentice Hall: Englewood Cliffs, New Jersey.

Guz, S.B. (1977) 'The Future of Psychiatry: Medicine or Social Science?' An Editorial, Journal of Nervous and Mental Disease, Vol.165, No.4, October, pp.225-230.

Hall, C.S. and Lindzey, G. (1970) Theories of Personality, Second Edition, John Wiley & Sons Inc: New York and London.

Harding, T.W., Adersballi, H. (1983) 'Assessments of Dangerousness: Observations in six countries: A summary of Results from a WHO Coordinated Study', International Journal of Law and Psychiatry, Vol.6, pp.391-398.

Hare, R. (1981) 'The philosphical basis of psychiatric ethics'. In Bloch, S. and Chadoff, P., Psychiatric Ethics, Oxford University Press: London and New York.

Harron, F. et al., (1983) Health and Human Values, Yale University Press: New Haven and London.

Hartmann, H. (1973) 'Psychoanalysis as a Scientific Theory'. In Millon, T. (ed.), Theories of Psychopathology and Personalities: Essay and Critiques, Second Edition, W.B. Saunders & Company: Philadelphia, London, Toronto.

Hasker, W. (1977) 'The Critique of "Mental Illness": Conceptual and/or Ethical Crisis?', Journal of Psych. and Theology, 5, 2, pp.110-124.

Hass, K. (1979) Abnormal Psychology, D. Van Nostrand & Company: U.K.

Heginbotham, C. (1982) 'The Rights of Mentally Ill People', The Minority Rights Group, No.74, London.

Helzer, J.E. et al., (1977) 'Reliability of psychiatric diagnosis: 1. A methodological review', Arch.Gen.Psychiatry, Vol.34, February, pp.129-133.

Holder, E. (1977) 'The Abuse of Psychiatry for Political Purposes', Journal of Child Psychotherapy, Vol.4, No.3, pp.108-110.

Holmes, W. and Solomon, P. (1981) 'Organisational and Client Influences on Psychiatric Admissions', Psychiatry, Vol.44, No.3, August, pp.201-209.

Humber, J.M. (1981) 'The Involuntary Commitment and Treatment of Mentally Ill Persons', Soc.Sci.Med., Vol.15F, pp.143-150.

Hussain, A. (1984) Old Kuwaiti Memories, Al-Slasal Publishing Company: Kuwait. Second Edition.

I.H.T. (1988) Friday 11 November No.32, p.881. U.S.A.

Ingham, J. (1985) 'The public image of psychiatry', Editorial, Soc.Psychology, Vol.20, pp.107-108.

Ingleby, D. (1981) 'Understanding "Mental Illness"'. In Ingleby, David (ed.), Critical Psychiatry, Penguin Books: U.K.

Irwin, M. et al., (1985) 'Psychotic patients' understanding of informed consent', American Journal of Psychiatry, 142, 11 November, pp.1351-1354.

Jablensky, N.S., Cooper, J.A. and Burke, J.D. (1988) 'Psychiatric classification in an international perspective', British Journal of Psychiatry (Suppl.1), Vol.152, May.

Jaspers, K. (1963) General Psychopathology. Translated by J. Hoenig and W.H.Marian, Manchester University Press: U.K.

Jones, K. and Fowler, A.J. (1984) Ideas on Institutions, Routledge and Kegan Paul: London and Boston.

Jung, C.G. (1961) The Psychogenesis of Mental Disease, Routledge and Kegan Paul: London and Boston, pp.212-244.

Kanfer, F.H. and Saslow, G. (1973) 'Behavioural Analysis: An alternative to diagnostic classification'. In Millon, T. (eds.), Theories of Psychopathology and Personality, W.B.Saunders & Co: U.S.A. and London, p.334.

Kanter, J. (1984) 'Moral Issues and Mental Illness', Bulletin of the Menninger Clinic, 48(6), pp.518-539.

Katz, D. (1979) Gestalt Psychology: Its nature and significance Greenwood Press: Westport, U.S.A.

Kendell, R.E. (1975) 'The concept of disease and its implications for psychiatry', British Journal of Psychiatry, Vol.127, pp.305-15.

Kendell, R.E. (1983) 'DSM-III: A major advance in psychiatric nosology'. In Spitzer, R.L. et al., (eds.), International Perspectives on DSM-III, American Psychiatric Press.

Kendler, K.S. (1987) 'Paranoid disorder in DSM-III: A critical review', in Tischler, G.L. (ed.), Diagnosis and Classification in Psychiatry: A critical appraisal of DSM-III, Cambridge University Press.

Kety, S.S. (1971) 'Toward Hypotheses for a biochemical component in the vulnerability to schizophrenia'. In Shean, G. (ed.), Dimensions in Abnormal Psychology, Rand McNally College Publishing Company: Chicago.

Kety, S.S. (1971) 'From Rationalisation to Reason'. In Shean, G., (ed.), Dimensions in Abnormal Psychology, College Publishing Company: Chicago.

Klein, D.F. (1978) 'A proposed definition of mental illness'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Klein, J.I. (1983) 'Psychiatric Malpractice', International Journal of Law and Psychiatry, Vol.6, pp.131-157.

Klerman, G.L. (1977) 'Mental Illness, the Medical Model and Psychiatry', Journal of Medicine and Philosophy, Vol.2, No.3, pp.220-243.

Klose, K. and Koryagin, A. (1985) 'A Question of Conscience'. In Stover, E., and Nightingale, E. (eds.), The Breaking of Bodies and Minds: Torture, Psychiatric Abuse, and Health Profession, W.H.Freeman & Co: New York, American Association for the Advancement of Science. p.175.

Koryagin, A. (1989) 'The Involvement of Soviet Psychiatry in the Persecution of Dissenters', British Journal of Psychiatry, 154, pp.336-340.

Kuwait Health Statistics (1985) Ministry of Public Health, Vol.24.

Lafitt, P. (1957) The Person in Psychology: Reality or Abstraction, Routledge and Kegan Paul: London and Boston.

Lahey, B.B. and Ciminero, A.R. (1980) Maladaptive Behaviour: An Introduction to Abnormal Psychology, Illinois, Scott Foresman and Company: Illinois.

Laing, R.D. (1960) The Divided Self, Tavistock Publications: London and New York.

Laing, R.D. (1983) The Voice of Experience, Penguin Books: U.K.

Laing, R.D. (1985) Wisdom, Madness and Folly: The making of a psychiatrist, Macmillan: U.S.A. and U.K.

Laing, R.D. and Esterson, A. (1970) Sanity, Madness and the Family, Penguin Books: U.K.

Laor,N. (1982) 'Szasz, Feuchtersleben, and the History of Psychiatry', Psychiatry, Vol.45, November, p.321 and p.324.

Laor,N. (1982) 'Old Whig Psychiatry: The Szaszian Variant', Israel Journal of Psychiatry and Related Sciences, Vol.19, No.3, pp.215-225.

Lavin, M. (1985) 'Doctors, psychiatrists and disease', Soc.Sci. Med., Vol.20, No.5, pp.535-543.

Lazane, A. (1981) 'Hidden Conceptual Models in Clinical Psychiatry'. In Caplan, A.L. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

Lazarus, R.S. (1975) 'The healthy personality - A Review of conceptualization and research'. In Levi, L., (ed.), Society Stress and Disease, Oxford University Press: London and New York.

Lederman, E.K. (1982) 'Ethics in Psychiatry - the patient's freedom and bondage', Journal of Medical Ethics 8, pp.191-194.

Leff, J. (1986) 'International variations in the diagnosis of psychiatric illness'. In Kerr, A. and Snaith, P. (eds.), Contemporary Issues in Schizophrenia, The Royal College of Psychiatrists: U.K.

Leiffer, R. (1969) In the Name of Mental Illness: The Social Functions of Psychiatry, Science House: New York.

Lemert, E.M. (1951) Social Pathology: A systematic approach to theory of sociopathic behavior, McGraw-Hill Books Company Inc: New York, London.

Lemert, E.M. (1967) Human Deviance, Social Problems, and Social Control, Prentice-Hall Inc: Englewood Cliffs, New Jersey.

Lesser, H. (1983) 'Consent, Competency and ECT: A philosopher's comment', Journal of Medical Ethics 9, pp.144-145.

Levinson, R.M., Ramsay, G. (1978) 'Dangerousness, Stress, and Mental Health Evaluations', Journal of Health and Social Behaviour, Vol.20 (June), pp.178-187.

Lewin, M. (1979) Understanding Psychological Research, John Wiley & Sons: U.K.

Lewis, A. (1953) 'Health as a social concept', The British Journal of Sociology, Vol.4, pp.109-124.

Lidz, C.W. et al., (1984) Informed Consent: A study of Decision-making in Psychiatry, The Guildford Press: New York, London.

Lidz, T. (1972) 'Schizophrenia, Laing and the Treatment of Psychosis'. In Boyers, R. and Orrill, R. (eds.), Laing and Anti-Psychiatry, Penguin Books: U.K.

Lidz, T. (1971) 'Family Studies and a Theory of Schizophrenia'. In Shean, G. (ed.) Dimensions in Abnormal Psychology, Rand McNally Publishing Company: Chicago, U.S.A.

Light, D.W. (1982) 'Learning to Label'. In Grove, W. (ed.), Deviance and Mental Illness, Sage Publications Inc: London and Beverly Hills.

Light, D. (1980) Becoming Psychiatrists: The Professional Transformation of Self, W. Norton & Co., Inc: New York and London.

Livermore, J.M. et al., (1968-69) 'On the Justifications for Civil commitment', University of Pennsylvania Law Review, Vol.117, pp.75-96.

Mackkawi, M. et al., (1982) Long-stay Chronic Psychiatric Patients in Kuwait: A retrospective and follow-up study, Department of Community Medicine, Faculty of Medicine, December, Kuwait.

Macklin, R. (1981) 'Mental Health and Mental Illness: Some problems of definition and concept formation'. In Caplan et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

MacMurray, J. (1939) The Boundaries of Science: A Study in the Philosophy of Psychology, Faber & Faber Ltd: London.

Margolis, J. (1978) 'The Concept of Disease'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Maher, B.A. (1966) Principles of Psychopathology, McGraw-Hill Book Co: New York and London.

Marks, J. and Greenfield, P. (1987) 'How the CIA assesses weaknesses: The Gittinger Personality Assessment System'. In Cohen, D. (ed.), The Power of Psychology, Croom Helm: London, New York.

Marson, D.C. et al., (1988) 'Psychiatric Decision-making in the Emergency Room: A research overview', American Journal of Psychiatry, 145:8 August, pp.918-925.

Martin, B.A. (1985) 'The Reliability of Psychiatric Diagnosis'. In Webster, C.D. et al., Dangerousness, Cambridge University Press: London and New York.

McGuire, M.T. and Essock-Vitale, S.M. (1981) 'Psychiatric Disorder in the context of evolutionary biology: A functional classification on behaviour', The Journal of Nervous and Mental Disease, Vol.169, No.11.

McGuire, R.J. (1973) 'Classification and the Problem of Diagnosis'. In Eysenck, J.H. (ed.), Handbook of Abnormal Psychology, Pitman Medical: U.K.

Mechanic, D. (1978) 'The Concept of Illness Behaviour'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Mechanic, D. (1967) 'Some Factors in Identifying and Defining Mental Illness'. In Scheff, T.J. (ed.), Mental Illness and Social Processes, Harper & Row Publishers: New York and London.

Mechanic, D. (1985) 'Social Science in relation to psychiatry'. In Shepherd, M. (ed.), Handbook of Psychiatry, Vol.5, The Scientific Foundation of Psychiatry, Cambridge University Press, London and New York.

Mellor, C.S. (1987) 'Aspects of Jasperian Psychopathology'. In Abstracts of Papers presented at the Quarterly and Annual Meeting of the Royal College of Psychiatrists, Winter Quarterly Meeting, 27-28 January.

Mendel, W.M. and Rapport, S. (1969) 'Determinants of the decision of psychiatric hospitalisation', Archives of General Psychiatry, 20, pp.321-328.

Merskey, H. and Shafran, B. (1986) 'Political Hazards in the Diagnosis of "sluggish schizophrenia"', British Journal of Psychiatry, 148, pp.247-256.

Meyerson, A.T. and Hamilton, J. (1985) 'Disability, Determination: Psychiatrists Needed, Commentary', Hospital and Community Psychiatry, April, Vol.36, No.4, pp.337.

Mezzich, J.E. et al., (1985) 'International experience with DSM-III', The Journal of Nervous and Mental Disease, Vol.173, No.12. pp 738-741.

Miles, A. (1987) The Mentally Ill in Contemporary Society, Basil Blackwell: Oxford. Second Edition, p.209.

Mill, J.S. (1910 - new edition 1972 - reprinted in 1983) 'Utilitarianism, Liberty, Representative Government', Selections from Auguste Comte and Positivism. Edited by H.B.Acton, Everyman's Library: London, Melbourne, Toronto.

Miller, P. and Rose, N. (1986) The Power of Psychiatry, Polity Press: Oxford.

Milner, N. (1981) 'Models of Rationality and Mental Health Rights', International Journal of Law and Psychiatry, Vol.4, pp.35-52.

Millon, T. (ed.) (1973) Theories of Psychopathology and Personality, W.B.Saunders ' Co: U.S.A. and London.

Millon, T. (1983) 'The DSM-III: An Insider's Perspective', American Psychologist, Vol.38, No.7, July, pp.804-814.

Ministry of Public Health (1961) Our Hospitals, Ministry of Public Health: Kuwait.

Monroe, R.R. (1982) 'The Disorder and its Diagnosis' Introduction Journal of Nervous and Mental Disease, Vol.170, No.11, November, pp.643-645.

Moore, M.S. (1982) 'Some Myths about Mental Illness'. In Edwards, R.B., Psychiatry and Ethics, Prometheus Books: London and U.S.A.

Moore, M.S. (1984) Law and Psychiatry, Cambridge University Press: London, pp.213-214.

Moore, M.S. (1983) 'Some Myths about "Mental Illness"'. In Vatz, R.E. and Weinberg, L.S. (eds.), Thomas Szasz: Primary Values and Major Contentions, Prometheus Books: New York and London.

Moore, M.S. (1978) 'Discussion of the Spitzer-Endicott and Klein Proposed Definitions of Mental Disorder (Illness)'. In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Murphy, T. (1982) 'Differential Diagnosis in Mental Illness', Journal of Medicine and Philosophy, 7, pp.327-335.

Natanson, M. (ed.) (1969) Psychiatry and Philosophy, Springer-Verlag: London.

Natham, P.E. (1980) Psychopathology and Society, McGraw-Hill: New York and London.

Newspaper of the American Psychiatric Association (1988) 'Psychiatric News', 5 February, Vol.XXIII, No.3, p.3.

Nightingale, E.O. and Stover, E. (1985) 'Towards the Prevention of Torture and Psychiatric Abuse'. In Stover, E. and Nightingale, E. (eds.), The Breaking of Bodies and Minds: Torture, Psychiatric Abuse, and the Health Profession, W.H.Freeman and Co: New York, American Association for the Advancement of Science, p.245.

Oelbaum, L.R. (1972) 'Clinical and Moral Views of Madness: Laing and Goffman Compared', Bulletin - Menninger Clinic September, 36, 5, pp.487-504.

Parsons, T. (1978) 'Definitions of Health and Illness in the light of American Values and Social Structure'. In Spitzer, R.L., and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Pattison, S. and Armitage, P. (1986) 'An Ethical Analysis of the Policies of British Community and Hospital Care for Mentally Ill People', Journal of Medical Ethics 12, pp.136-140.

Peele, S. (1981) 'Reductionism in the Psychology of the Eighties', American Psychologist, Vol.36, No.8, August, p.816.

Perry, C. (1985) 'A problem with Refusing Certain Forms of Psychiatric Treatment', Soc.Sci.Med. Vol.20, No.6, pp.645-648.

Perrucci, R. and Targ, D.B. (1982) 'Network Structure and Reactions to Primary Deviance of Mental Patients', Journal of Health and Social Behaviour, Vol.23, March, pp.2-17.

Persons, J.B. (1986) 'The Advantages of Studying Psychological Phenomena Rather Than Psychiatric Diagnosis', American Psychologist, Vol.41, No.11, November, pp.1252-1260.

Pflanz, M. and Rohde, J.R. (1970) 'Illness: Deviant Behaviour or Conformity', Soc.Sci.Med., Vol.4, pp.645-653.

Pies, R. (1979) 'On Myths and Countermyths': More on Szaszian Fallacies', Arch.Gen.Psychiatry, Vol.36, February, pp.355-360.

Pies, R. (1983) 'On Myths and Countermyths' in Vatz, R.E., and Weinberg, L.S., Thomas Szasz: Primary Values and Major Contentions, Prometheus Books: New York, p.196.

Pinkard, T. (1976) 'Interpretation and verification in the human sciences: A note on Taylor', Phil.Soc.Sci., Vol.6, pp.165-173.

Plog, S.C. and Edgerton, R.B. (eds.) (1969) Changing Perspective in Mental Illness, Holt, Rinehart and Winston Inc: U.K. and U.S.A.

Price, R.H. and Denner, B. (eds.) (1973) The Making of a Mental Patient, Holt, Rinehart and Winston, Inc: U.K and U.S.A.

Psychiatric News (1988) Newspaper of the American Psychiatric Association, 15 April, No.3.

Psychiatric News (1988) Newspaper of the American Psychiatric Association, 17 June.

Quran Al-Harameen (1983) Al-Halabig Publishing Company: Egypt.

Rack, P. (1982) Race, Culture and Mental Disorder, Tavistock Publications: London, New York.

Redlich, F.C. (1981) 'The Concept of Health in Psychiatry'. In Caplan, A.L. et al., (eds.), Concepts of Health and Diseases, Addison-Wesley Publishing Company: U.K.

Reich, W. (1984) 'Psychiatric diagnosis as an ethical problem'. In Bloch, S. and Chadoff, P. (eds.), Psychiatric Ethics Oxford University Press: Oxford and New York, p.67 and p.69.

Reich, W. (1985) 'The World of Soviet Psychiatry' In Stover, E. and Nightingale, E. (eds.), The Breaking of Bodies and Minds: Torture, Psychiatric Abuse, and the Health Profession, W.H.Freeman & Co: New York, American Association for the Advancement of Science.

Reich, W. (1985) 'The Case of General Grigorenko: A Second Opinion', Ibid.

Reidbord, S.P. (1986) 'Inappropriate objectivity in psychiatry', The Journal of Medical Humanities and Bioethics, Vol.7, No.2 Fall/Winter, pp.133-134.

Rey, J.M. et el., (1987) 'Sources of Unreliability of DSM-III Axis IV', Australian and New Zealand Journal of Psychiatry 21, pp.75-80.

Rey, J.M. et al., (1988) 'DSM-III Axis IV Revisited', American Journal of Psychiatry, 145:3 March, pp.286-292.

Rieder, R.O. (1971) 'The Origins of our confusion about schizophrenia'. In Shean, G. (ed.), Dimensions in Abnormal Psychology, Rand McNally, College Publishing Company: Chicago.

Rimm, D.C. and Somerville, J.W. (1977) Abnormal Psychology, Academic Press: New York and London, p.36.

Robins, L.N. and Helzer, J.E. (1986) 'Diagnosis and Clinical Assessment: The current state of psychiatric diagnosis', Annual Review of Psychology, p.418.

Robitscher, J. (1977a) 'Psychiatric Labelling, Predicting, and Stigmatizing', The Journal of Psychiatry and Law.

Robitscher, J. (1977b) 'Psychiatric Control of Behaviour', The Journal of Psychiatry and Law.

Rogers, C.R. (1951) Client Centered Therapy, Constable: London.

Rogers, C.R. (1961) On Becoming a Person: A Therapist's View of Psychotherapy, Constable: London.

Rosenhan, D.L. (1975) 'The contextual nature of psychiatric diagnosis', Journal of Abnormal Psychology, Vol.84, No.5, pp.462-474.

Rosenhan, D.L. (1976) 'On being sane in insane place'. In Shean, G. (ed.), Dimensions in Abnormal Psychology, Rand McNally College Publishing Company: Chicago.

Rosie, J.S. (1987) 'Partial Hospitalization: A review of recent literature', Hospital and Community Psychiatry, December, Vol.38, No.12.

Rossabi, A. (Interviewer) (1972) 'Anti-psychiatry: an overview with Dr. Joseph Berke. In Boyers, R. and Orrill, R. (eds.), Laing and Anti-psychiatry, Penguin Books: U.K.

Roth, M. (1976) 'Schizophrenia and the theories of Thomas Szasz', British Journal of Psychiatry, 129, pp.317-326.

Roth, M. and Bluglass, R. (1985) Pyschiatry, Human Rights and the Law, Cambridge University Press: London and New York, p.101.

Roth, M. and Kroll, J. (1986) The Reality of Mental Illness, Cambridge University Press: London and New York.

Runions, J.E. (1984) 'Whatsoever Things Are True: Ways, Means and Values in Modern Psychiatry', Canadian Journal of Psychiatry, Vol.29, April, pp.223-227.

Ruse, M. (1978) 'Are Homosexuals Sick?' In Spitzer, R.L. and Klein, D.F. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Ryan, A. (1987) The Philosophy of John Stuart Mill, Second Edition, Macmillan Press: London.

Sarason, I.G. and Sarason, B. (1987) Abnormal Psychology: The problem of maladaptive behaviour, Prentice-Hall Inc., Fifth Edition: U.K.

Sarbin, T.R. (1967) 'On the futility of the proposition that some people be labelled "Mentally Ill"', Journal of Consulting Psychology, Vol.31, No.5, pp.447-453.

Sarbin, T.R. (1969) 'The Scientific Status of the Mental Illness Metaphor'. In Plog, S.C. and Edgerton, R.B., (eds.), Changing Perspectives in Mental Illness, Holt, Rinehart and Winston, Inc: U.K. and U.S.A.

Sayers, S. (1973) 'Mental Illness as a moral concept', Radical Philosophy, 5, pp.2-8.

Schacht, T.E. (1985) 'DSM-III and the Politics of Truth', American Psychologist, No.4, May, pp.513-521.

Schatzman, M. (1971) 'Madness and Morals'. In Boyer, R. and Orrill, R. (eds.), Laing and Anti-Psychiatry, Penguin Books: U.K.

Scheff, T.J. (1967) Mental Illness and Social Processes, Harper and Row Publishers: New York and London.

Scheff, T.J. (1971) 'Schizophrenia As Ideology'. In Shean, G. (ed.), Dimensions in Abnormal Psychology, Rand McNally College Publishing Company: Chicago.

Scheff, T.J. (1975) 'On Reason and Sanity: Some political implications of psychiatric thought'. In Scheff, T.J. (ed.), Labelling Madness, Prentice-Hall Inc: London and U.S.A., Englewood Cliffs, New Jersey.

Scheff, T.J. (1984) Being Mentally Ill, Aldine: New York, p.193.

Schoenfeld, C.G. (1983) 'An Analysis of the Views of Thomas Szasz'. In Vatz, R. and Weinberg, Lee S. (eds.), Thomas Szasz: Primary values and major contentions, Prometheus Books: London and U.S.A.

Schrag, P. (1980) Mind Control, Marion Boyars: London, Boston.

Schwab, J.J. and Schwab, M.E. (1978) Sociocultural Roots of Mental Illness: An Epidermologic Survey, Plenum Medical Books Company: London, p.121.

Schwatz, M.A. and Wiggins, O.P. (1987) 'Diagnosis and Ideal Type: A contribution to Psychiatric Classification', Comprehensive Psychiatry, Vol.28, No.4, July/August, pp.277-291.

Scott, W.A. (1971) 'Research Definitions of Mental Health and Mental Illness'. In Shean, G.D. (ed.), Studies in Abnormal Behaviour, Rand McNally & Co: Chicago.

Segal, B.E. (1965) 'Psychiatrist and Sociologist: Social System, Subculture, and Division of Labour', Journal of Health and Human Behaviour, Winter, Vol.6, No.4, pp.207-217.

Sedgwick, P. (1982) 'Illness -Mental and Otherwise'. In Edwards, Rem.B., Psychiatry and Ethics, Prometheus Books: London and U.S.A.

Sedgwick, P. (1982) 'Anti-Psychiatry from the Sixties to the Eighties'. In Gove, W.R. (ed.), Deviance and Mental Illness, Sage Publication: Beverly Hills, London.

Shaval, J.T. (1981) 'The contribution of psychological and social phenomena to an understanding of the aetiology of disease and illness', Soc.Sci.Med., Vol.15A, pp.337-342.

Sherlock, R. (1983) 'Consent, competency and ECT: Some critical suggestions', Journal of Medical Ethics 9, pp.141-143 (Symposium 1).

Shershow, J.C. (ed.) (1978) Schizophrenia: Science and Practice Harvard University Press: Cambridge, Mass., and London.

Siegler, M., Osmond, H. and Mann, H. (1972) 'Laing's models of madness'. In Boyers, R. and Orrill, R. (eds.), Laing and Anti-psychiatry, Penguin Books: U.K. (Reprinted in 1973), pp.102-103.

Siegler, M. and Osmond, H. (1974) Modes of Madness, Model of Medicine, Collier Macmillan: London.

Shepherd, M. et al., (1979) Explanations of Mental Illness, an editorial paper presented at the 72nd Annual Meeting of the American Sociological Association, Chicago, September, p.385.

Siever, L.J. and Kendler, K.S. (1987) 'An evaluation of the DSM-III categories of paranoid schizoid, and schizotypal personality disorders'. In Tischler, T.L. (ed.), Diagnosis and Classification in Psychiatry: A critical appraisal of DSM-III, Cambridge University Press: London and New York.

Simon, J. and Zusman, J. (1983) 'The effect of contextual factors on psychiatrist' perceptions of illness: A case study', Journal of Health and Social Behaviour, Vol.14 (June), pp.186-198.

Skinner, B.F. (1973) 'Critique of Psychoanalytic Concepts and Theories'. In Millon, T. (ed.), Theories of Psychopathology and Personality: Essays and Critiques Second Edition, W.B.Saunders & Co: Philadelphia, London, Toronto.

Skinner, B.F. (1987) 'Whatever Happened to Psychology as the Science of Behaviour?', American Psychologist, Journal of the American Psychological Association, Vol.42, No.8, pp.780-786.

Slavney, P.R. and McHugh, P.R. (1987) Psychiatric Clarities, Methodology and Practice, Johns Hopkins University Press International Book Distributor (IBD): U.K.

Smith, A.G. (1982) Schizophrenia and Madness, George Allen & Unwin: London, Boston, Sydney.

Spitzer, R.L. (1985) 'DSM-III and the Politics-Science Dichotomy Syndrom', American Psychologist, Vol.40, No.5, May, pp.522-526.

Spitzer, R. and Endicott, J. (1978) 'Medical and mental disorder: Proposed definition and criteria. In Spitzer, R. and Klein, D. (eds.), Critical Issues in Psychiatric Diagnosis, Raven Press: New York.

Steadman, H.J. (1983) 'Predicting Dangerousness among the Mentally Ill: Art, Magic and Science', International Journal of Law and Psychiatry, Vol.6, pp.381-89.

Steene, J. (1984) Ethics in Clinical Psychology, Oxford University Press: Cape Town and London.

Stevenson, L. (1977) 'Mind, Brain and Mental Illness', Philosophy, 52.

Straus, E.W., Natanson, M. (eds.) and Ey, H. (1969) Psychiatry and Philosophy, Springer-Verlag: London.

Szasz, T.S. 1983 'Autonomy', In Vatz, R.E. and Weinberg, L.S. Thomas Szasz: Primary Values and Major Contentions, Prometheus Books: New York.

Szasz, T.S. 'Authenticity and Humanism', Ibid.

Szasz, T.S. 'Mental Therapy is a Myth', Ibid.

Szasz, T.S. 'Three Questions and Answers as Contentions', Ibid.

Szasz, T.S. (1960) 'The Myth of Mental Illness', American Psychologist, 15, pp.113-118.

Szasz, T.S. (1962) 'Bootlegging Humanistic Values Through Psychiatry', Antioch Review, Fall, 22, pp.341-349.

Szasz, T.S. (1972) The Myth of Mental Illness, Paladin Books, Grafton Books: London.

Szasz, T.S. (1973) Ideology and Insantity, Marion Boyars: London and New York.

Szasz, T.S. (1979) Schizophrenia: The Sacred Symbol of Psychiatry, Oxford University Press: London, New York.

Szasz, T.S. (1979) 'The Lying Truths of Psychiatry', J.Liber.Stud., Summer, 3, pp.121-139.

Szasz, T.S. (1981) 'The Concept of Mental Illness: Explanation or Justification?' In Caplan, A.L. et al., Concept of Health and Disease, Addison-Wesley Publishing Company: U.K., p.459.

Szasz, T.S. (1981) 'On Preventing Psychopathology: A Libertarian Analysis'. In Joffe, J.M. and Albee, G.W. Prevention Through Political Action and Social Change, University Press of New England: Biblios U.K., p.29.

Szasz, T.S. (1984) The Therapeutic State, Prometheus Books: New York.

Szasz, T.S. (1987) Insanity: The idea and its consequences, John Wiley & Sons: London and New York.

Tarrier, N. (1979) 'The Future of the Medical Model', The Journal of Nervous and Mental Disease, Vol.167, No.2, February, pp.71-73.

Taylor, F.K. (1981) 'The Medical Model of the Disease Concept'. In Caplan, A. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

Taylor, S.E. and Brown, J.D. (1988) 'Illusions and well-being: A social psychological perspective on mental health', Psychological Bulletin, Vol.103, No.2, pp.193-210.

Taylor, P.J. (1983) 'Consent, Competency and ECT: A psychiatrist's view', Journal of Medical Ethics 9, pp.146-152 (Symposium 3).

Toncredi, L.R. (1972) Ethical Policy in Mental Health Care, Prodist: New York and London.

Toncredi, L.R. (1982) 'Competency for Informed Consent: Conceptual Limits of Empirical Data', International Journal of Law and Psychiatry, Vol.5, pp.51-63.

Torrey, E.F. (1985) Surviving Schizophrenia: A family manual, Harper Colophon Books (Harper & Row Publishers): New York, Cambridge.

Torrey, E.F. (1974) The Death of Psychiatry, Chilton Book Company (O.P.): U.S.A.

Townsend, J.M. (1978) Cultural Conception and Mental Illness: A comparison of Germany and America, University of Chicago Press, May.

Townsend, J.M. (1980) 'Psychiatry versus Societal Reaction: A Critical Analysis', Journal of Health and Social Behaviour, Vol.21, September, pp.268-278.

Treacher, A. and Barach, G. (1981) 'Towards a critical history of the psychiatric profession'. In Ingleby, D. (ed.), Critical Psychiatry: The Politics of Mental Health, Penguin Books: U.K.

Tucker, G.J. and Maxman, J.S. (1973) 'The Practice of Hospital Psychiatry: A formulation', American Journal of Psychiatry, 130:8 August, pp.887-891.

Twaddle, A.C. (1973) 'Illness and Deviance', Soc.Sci.Med., Vol.1, pp.751-762.

Tyner, P. and Steinberg, D. (1987) Models for Mental Disorders: Conceptual Models in Psychiatry, John Wiley & Sons: Chichester, New York.

Ullman, L.P. and Krasner, L. (1973) 'The Psychological Model'. In Millon, T. (ed.), Theories of Psychopathology and Personality, W.B.Saunders Company: U.K. and U.S.A.

Valentine, E.R. (1982) Conceptual Issues in Psychology, George Allen & Unwin: London, Boston, Sydney.

Vatz, R.E. and Weinberg, Lee S. (eds.) (1983) Thomas Szasz: Primary Values and Major Contentions, Prometheus Books: U.S.A.

Vatz, R.E., Rappaport, J. and Weinberg, L.S. (1983) 'Comment and Controversy'. In Vatz, R.E. and Weinberg, L.S., Thomas Szasz: Primary Values and Major Contentions, Prometheus Books: New York.

Veatch, R.M. (1981) 'The Medical Model: Its nature and problems'. In Caplan, Arthur L. et al., (eds.), Concept of Health and Disease, Addison-Wesley Publishing Company: U.K.

Walker, N. (1985) 'Psychiatric explanation as excuses'. In Roth, M. and Bluglass, R., Psychiatry, Human Rights and the Law, Cambridge University Press: London and New York.

Walker, S. (1984) Learning Theory and Behaviour Modification, Methuen & Co., London.

Wear, S. (1980) 'Mental Illness and Moral Status', Journal of Medicine and Philosophy, p.304 and p.307 (pp.292-312).

Webster's Ninth New Collegiate Dictionary (1983) Merriam-Webster Inc., Publishers: U.S.A.

Webster, C.D. et al., (1985) Dangerousness, Cambridge University Press: London.

Weinberg, J. (1978) 'The Chronic Patient: The Stranger in our midst', Hospital and Community Psychiatry, Vol.29, No.1, January, pp.25-28.

Weinberg, L.S. and Vatz, R.E. (1983) 'The Mental Illness Dispute: The critical faith assumptions'. In Vatz, R.E. and Weinberg, L.S., Thomas Szasz: Primary values and major contentions, Prometheus Books: New York.

Weinberg, L.S. and Vatz, Richard E. (1983) 'Szasz and the Law: An alternative view', Ibid.

Weinstein, R.M. (1981) 'Attitudes Towards Psychiatric Treatment Among Hospitalised Patients: A review of quantitative research', Soc.Sci.Med., Vol.15E, pp.301-314.

Weinstein, R.M. (1983) 'Labelling Theory and the Attitudes of Mental Patients: A review', Journal of Health and Social Behaviour, Vol.24, March, pp.70-84.

Wigg, N. (1983) 'DSM-III: A perspective from the third world'. In Spitzer, R.L. et al., (eds.), International Perspectives on DSM-III, American Psychiatric Press: U.S.A.

Williams, J.B.W. (1985) 'The multiaxial system of DSM-III: Where did it come from and where should it go? 1. Its origins and critiques', Arch.Gen.Psychiatry, Vol.42, February, pp.175-180.

Wing, J.K. (1978) Reasoning about Madness, Oxford University Press: London.

Wolpe,J., Rachman.S.(1974) 'Psychoanalytic Evidence: A critique based on Freud's case of little Hans'. In Neale, J.M. et al., (eds.), Contemporary Readings in Psychopathology, John Wiley & Sons Inc: New York, London, Sydney, Toronto.

Wood, G. (1984) The Myth of Neurosis: A case for moral therapy, Papermac, a division of Macmillan: London, p.35.

World Health Organisation (1978) Mental Disorders: Glossary and Guide to Their Classification in accordance with the Ninth Revision of the International Classification of Diseases, World Health Organisation: Geneva.

Zubin, J. and Spring, B. (1977) 'Vulnerability - a new view of schizophrenia', Journal of Abnormal Psychology 86, pp.103-126.

Zwi, A.B. (1987) 'The Political Abuse of Medicine and the Challenge of Opposing It', Soc.Sci.Med., Vol.25, No.6, pp.649-657.